BCBSM Physician Group Incentive Program

Patient-Centered Medical Home and Patient-Centered Medical Home-Neighbor

Interpretive Guidelines

2018-2019

Table of Contents

Contents

READ ME FIRST: THE ESSENTIAL FAQS ABOUT THE PATIENT-CENTERED MEDICAL HOME AND PATIENT-CENTERED MEDICAL HOME-NEIGHBOR PROGRAM 3

1. *WHAT IS THE PATIENT-CENTERED MEDICAL HOME AND PATIENT-CENTERED MEDICAL HOME-NEIGHBOR?* 3

2. *WHY ARE THERE ALL THESE "CAPABILITIES?"* 3

3. *WHY DO WE NEED "INTERPRETIVE GUIDELINES?"* 4

5. *WHO IS RESPONSIBLE FOR REPORTING PCMH/PCMH-N CAPABILITIES TO BCBSM?* .. 4

6. *CAN WE REPORT A CAPABILITY IN PLACE AS SOON AS THE PRACTICE HAS THE ABILITY TO USE IT? OR WHAT ABOUT WHEN ONE PHYSICIAN OR MEMBER STARTS USING IT?* 4

7. *THE PCPS IN MY PO ARE VERY FAMILIAR WITH THE PCMH MODEL, BUT OUR SPECIALISTS HARDLY KNOW WHAT WE'RE TALKING ABOUT. SOME OF THEM THINK THEY SHOULD BE THEIR PATIENT'S MEDICAL HOME, NOT THE PCP. WHAT SHOULD WE DO ABOUT THIS?* 5

8. *WHY IS IT SO IMPORTANT THAT THE CAPABILITIES BE REPORTED ACCURATELY?* 6

9. *DO WE HAVE TO IMPLEMENT THE CAPABILITIES IN ORDER?* 6

10. *DON'T YOU PEOPLE KNOW HOW TO COUNT? WHAT HAPPENED TO DOMAIN 7 AND WHY DOES DOMAIN 8 START AT 8.7?* 6

11. *WHAT DOES PCMH/PCMH-N HAVE TO DO WITH ORGANIZED SYSTEMS OF CARE?* ... 6

12. *WHY DOES BCBSM DO ALL THOSE SITE VISITS AND HOW SHOULD PHYSICIAN ORGANIZATIONS PREPARE PRACTICES?* 6

13. *WHAT DO YOU MEAN BY "CO-MANAGEMENT?"* 7

14. *YOU USE THE TERM "CLINICAL PRACTICE UNIT TEAMS" A LOT. WHAT DOES THAT MEAN?* 7

15. WHY AREN'T THERE ANY CAPABILITIES RELATED TO HEALTH LITERACY? 8

PCMH/PCMH-N INTERPRETIVE GUIDELINES 8

2.0 PATIENT REGISTRY 14
4.0 INDIVIDUAL CARE MANAGEMENT 34
10.0 LINKAGE TO COMMUNITY SERVICES 68
11.0 SELF-MANAGEMENT SUPPORT 72
13.0 COORDINATION OF CARE 81

Blue Cross Blue Shield of Michigan
Physician Group Incentive Program

Patient-Centered Medical Home
And Patient-Centered Medical Home-Neighbor
Interpretive Guidelines

READ ME FIRST: THE ESSENTIAL FAQS ABOUT THE PATIENT-CENTERED MEDICAL HOME AND PATIENT-CENTERED MEDICAL HOME-NEIGHBOR PROGRAM

1. What is the Patient-Centered Medical Home and Patient-Centered Medical Home-Neighbor?

The Patient-Centered Medical Home (PCMH) is a care delivery model in which patient treatment is coordinated through primary care physicians to ensure patients receive the necessary care when and where they need it, in a manner they can understand. The PCMH-Neighbor model enables specialists and sub-specialists, including behavioral health providers, to collaborate and coordinate with primary care physicians to create highly functioning systems of care.

The goals of the PCMH/PCMH-N model are to:

- Strengthen the role of the PCP in the delivery and coordination of health care
- Support population health management, which uses a variety of individual, organizational and cultural interventions to help improve the illness and injury burden and the health care use of defined populations.
- Ensure effective communication, coordination and integration among all PCP and specialist practices, including appropriate flow of patient care information, and clear definitions of roles and responsibilities

2. Why are there all these "capabilities?"

When BCBSM began developing its PCMH program in 2008 in collaboration with PGIP Physician Organizations (POs), it became clear that practices could not wave a wand and turn into a fully realized PCMH overnight. In early demonstration projects, practices began suffering from transformation fatigue, in some cases leading to disillusionment with the PCMH model.

In partnership with the PGIP community, BCBSM decided to develop 12 initiatives to support incremental implementation of PCMH infrastructure and care processes. Each initiative focuses on a

PCMH domain of function and defines the set of capabilities that will enable practices to achieve the PCMH vision for that domain of function.

Initially, a 13th initiative was developed for electronic prescribing (domain 8), but then a separate e-prescribing incentive program was implemented, and e-prescribing was removed from the list of PCMH/PCMH-N domains. In the 2016-2017 version of the Interpretive Guidelines, domain 8 was resurrected to add capabilities related to electronic prescribing and management of controlled substance prescriptions.

3. *Why do we need "Interpretive Guidelines?"*

During the first round of site visits in 2009, we rapidly discovered that there were widely varying interpretations of nearly every term and concept in the PCMH model. We created the Interpretive Guidelines to provide definitions, examples, links to helpful resources, and to address questions regarding extenuating circumstances.

The Interpretive Guidelines continue to evolve, and now include "PCMH Validation Notes," which are examples of the ways in which a practice may be asked to demonstrate that capabilities are in place during the site visit validation process. Please note that these are just illustrative examples; during the actual site visit a practice may be asked different or additional questions.

4. *Why have new capabilities been added over time, and why are some capabilities being retired?*

Although the PCMH/PCMH-N model was designed to be highly aspirational, it also continues to evolve based on new research and insights about the delivery of optimal health care. Each year, BCBSM conducts a comprehensive review of the Interpretive Guidelines, incorporating input gathered from the PGIP community throughout the year, and new capabilities are added as needed based on new findings.

Starting in 2017, capabilities are retired when they no longer require substantive time and or resources to implement, due to the evolution of practice transformation.

5. *Who is responsible for reporting PCMH/PCMH-N capabilities to BCBSM?*

Physician Organizations are responsible for reporting PCMH/PCMH-N capabilities to BCBSM. Capabilities can be reported online at any time, using the Self-Assessment Database. Twice a year, in January and July, BCBSM takes a "snapshot" of the self-reported data.

It is not acceptable for a PO to request that practices simply self-report their capabilities. POs must be actively engaging and educating their practices about the PCMH/PCMH-N model and must validate all capabilities before reporting them in place.

6. *Can we report a capability in place as soon as the practice has the ability to use it? Or what about when one physician or member starts using it?*

No and no. Any capability reported to BCBSM as "in place" must be fully in place and in use by all appropriate members of the practice unit team on a routine and systematic basis, and, where

applicable, patients must be actively using the capability. Some examples the field team has seen of capabilities that should not have been marked in place are:

- Patient portal capabilities reported as in place: Practice has patient portal implemented, but no providers or patients are using it.

- After hours/urgent care capabilities reported as in place for specialty practice: urgent care centers are identified in the PO's PCMH brochure the practice is giving to patients, but specialty practice says they don't use urgent care and do not counsel patients about how to receive after hours/urgent care, but instead direct patients to the ED.

7. *The PCPs in my PO are very familiar with the PCMH model, but our specialists hardly know what we're talking about. Some of them think they should be their patient's medical home, not the PCP. What should we do about this?*

It is critical that prior to reporting PCMH-N capabilities in place, POs ensure that both allopathic and non-allopathic specialists are aware of and in agreement with the PO's documented guidelines outlining basic expectations regarding the role of specialists in the PO and within the PCMH/PCMH-N model, including:

- Commitment to support the PCMH/PCMH-N model and the central role of the PCP in managing patient care and providing preventive and treatment services, including immunizations
- Willingness to actively engage with the PO to optimize cost/use of services
- Collaboration with PCPs and other specialists to coordinate care

In addition, POs should:

- Visit specialist practices to determine which capabilities are in place and actively in use. (The only exceptions would be those capabilities that are centrally deployed by the PO, such as generation of patient alerts and reminders.) POs should also ensure that specialist practices are aware of, and in agreement regarding, which PCMH-N capabilities are reported as in place for their practice.
- Hold forums and visit practices to educate the specialists and their teams about the PCMH-N model, and, importantly, emphasize the need for specialists to actively engage with the PO and their PCP colleagues to optimize individual patient care management and population level cost and quality performance.

Please remember that the point of the PCMH-N program is not to reward specialists for capabilities that just happen to be in place; the purpose is to enable POs to engage specialists in the PCMH-N model, with the goal of building an integrated, well-coordinated medical neighborhood.

As of 2017, if the field team finds during the course of a site visit that any of these elements are missing (e.g., the practice does not understand or support the PCMH/PCMH-N model, has not been visited/educated by the PO, is not aware of which capabilities have been reported in place, etc.), the field team reserves the right to suspend the site visit and take other remedial steps as deemed appropriate.

8. *Why is it so important that the capabilities be reported accurately?*

Accurate reporting of PCMH-N capabilities is vital, for many reasons:

- The overall integrity of PGIP and the PCMH Designation Program depends upon POs accurately reporting on their transformation efforts. Currently, a minimum of 50 PCMH capabilities must be in place for a practice to be designated. The continued success of the program requires that BCBSM and PGIP POs are fully aligned in support of PGIP's goals, and that POs are committed to ensuring the accuracy of their self-reported data.
- Our PCMH/PCMH-N database is the source for extensive analytics and articles published in national peer-reviewed journals regarding the effectiveness of the PCMH and PCMH-N models.
- Inaccurate data will lead to misleading results, which could negatively affect the programmatic and financial viability of the PCMH/PCMH-N model.
- Inaccurate reporting of PCMH-N capabilities leads to inappropriate allocation of PGIP rewards, reducing the amount available to reward other key PGIP activities

9. *Do we have to implement the capabilities in order?*

Capabilities are not necessarily listed in sequential order (except for patient-provider partnership capabilities) and may be implemented in any sequence the PO and/or practice unit feels is most suitable to their practice transformation strategy.

10. *Don't you people know how to count? What happened to domain 7 and why does domain 8 start at 8.7?*

Sort of. Because we have amassed years of self-reported data based on numbered capabilities, we cannot reassign capability numbers. Domain 7 was previously used to collect evidence-based care data and has been retired. In domain 8, capabilities 8.1 through 8.6 were related to incremental implementation of e-prescribing and have been retired.

11. *What does PCMH/PCMH-N have to do with Organized Systems of Care?*

In a word, everything. BCBSM's PCMH/PCMH-N program provides the foundation to build Organized Systems of Care (OSCs).

12. *Why does BCBSM do all those site visits and how should Physician Organizations prepare practices?*

Site visits are a vital component of BCBSM's PCMH/PCMH-N program, and serve to:

- Educate POs and practice staff about the PCMH/PCMH-N Interpretive Guidelines and BCBSM expectations
- Enable the field team to gather questions and input to refine, clarify, and enhance the PCMH/PCMH-N Interpretive Guidelines
- Ensure that the PCMH/PCMH-N database is an accurate source for research as well as the PCMH Designation process

POs should inform practices that demonstration will be required for certain capabilities. For example, if the practice is asked to show the field team how patient contacts were tracked in the practice system for abnormal test results, the practice should have patient examples identified ahead of time and be prepared to discuss them with the field team during the site visit.

All requested documentation must be available and provided **during** the site visit.

13. *What do you mean by "co-management?"*

There are several types of co-management between PCPs and specialists, as well as other interactions, as defined in the table below.

Types of PCP/Specialist Clinical Interactions
Pre-consultation exchange - Expedite/prioritize care, clarify need for a referral, answer a clinical question and facilitate the diagnostic evaluation of the patient prior to specialty assessment
Formal consultation - Deal with a discrete question regarding a patient's diagnosis, diagnostic results, procedure, treatment or prognosis with the intention that the care of the patient will be transferred back to the PCMH/PCP after one or two visits.
Co-management • *Co-management with shared management for the disease* – specialist shares long-term management with the PCP for a patient's referred condition and provides advice, guidance and periodic follow-up for one specific condition. • *Co-management with principal care for the disease* – (referral) the specialist assumes responsibility for long-term, comprehensive management of a patient's referred medical/surgical condition; PCP receives consultation reports and provides input on secondary referrals and quality of life/treatment decisions; PCP continues to care for all other aspects of patient care and new or other unrelated health problems and remains first contact for patient. • *Co-management with principal care of the patient for a consuming illness for a limited period* – when, for a limited time due to the nature and impact of the disease, the specialist becomes first contact for care until the crisis or treatment has stabilized or completed. PCP remains active in bi-directional information and provides input on secondary referrals and other defined areas of care.
Transfer of patient to specialist - Transfer of patient to specialist for the entirety of care.

14. *You use the term "clinical practice unit teams" a lot. What does that mean?*

"Clinical Practice Unit teams" should be composed of "clinicians," defined as physicians, nurse practitioners, or physician assistants (unless otherwise specified in the guidelines).

15. Why aren't there any capabilities related to health literacy?

Health literacy should be considered across all relevant domains. All verbal and written communications with patients must be appropriate to the specific level of understanding and needs of the individual patient.

Capabilities Overview

		Required Capabilities	Retired Capabilities	Total Active Caps Applicable for Adult Patients	Total Active Caps Applicable for Pediatric Patients	Total Number of Capabilities	Total # Active Capabilities
1.0	PPP	1.1	1.9	11	11	12	11
2.0	Patient Registry		2.5	18	20	23	22
3.0	Performance Reporting			15	17	18	18
4.0	Individual Care Management	4.6		28	28	28	28
5.0	Extended Access	5.1		10	10	10	10
6.0	Test Tracking	6.2 6.5	6.3	8	8	9	8
8.0	Electronic Prescribing			5	5	5	5
9.0	Preventive Services			9	9	9	9
10.0	Linkage to Community Services	10.2		8	8	8	8
11.0	Self-Management Support			8	8	8	8
12.0	Patient Web Portal		12.1, 12.2, 12.8	11	11	14	11
13.0	Coordination of Care			12	12	12	12
14.0	Specialist Referral Process		14.3, 14.5, 14.10	8	8	11	8
	TOTAL NUMBER	**6**	**9**	**151**	**155**	**167**	**158**

PCMH/PCMH-N INTERPRETIVE GUIDELINES

1.0 Patient-Provider Partnership

Goal: Build provider care team and patient awareness of, and active engagement with, the PCMH model, clearly define provider and patient responsibilities, and strengthen the provider-patient relationship.

a. Providers have an established process for repeating Patient-Provider Partnership discussion, particularly with non-adherent patients and patients with significant change in health status
b. Providers track date of Patient-Provider Partnership discussion and repeat discussion at least every 2-3 years

Required for PCMH Designation: NO	Predicate Logic: n/a

1.11

Practice has a regularly scheduled in-person new patient orientation that is distinct from a regularly scheduled visit, to set expectations about being a patient within that practice, and provide education about the value of a patient-centered medical home model.

PCP and Specialist Guidelines:

a. Orientation can be in a group setting and led by a mid-level provider or nurse

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Show agendas, patient handouts, meeting schedules for new patient orientation	

1.12

Practice establishes a Patient and Family Advisory Council to better understand patient and caregiver perspectives, and how those perspectives can be used to optimize patient care.

PCP and Specialist Guidelines:

a. For more information on creating a Patient and Family Advisory Council, review this module from the American Medical Association: https://www.stepsforward.org/modules/pfac
b. Cannot be solely hospital-based
c. Patients on committee must be current patients of the practice or their family members

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Show agendas, meeting schedules, attendee list for PFAC • Show examples of patient feedback collected from PFAC and demonstrate how change was enacted based on feedback	

2.0 Patient Registry

Goal: Enable providers to manage their patients both at the population level and at point of care through use of a comprehensive patient registry.

23 total capabilities; 1 retired.
Capabilities 2.11, 2.12 and 2.16 applicable to: Adult Patients only

Capabilities 2.17, 2.18, 2.22, and 2.23 applicable to: Peds Patients only

Applicable to PCPs; and to specialists for the patients for whom they have primary or co-management responsibility (regardless of insurance coverage and including Medicare patients).

For all Patient Registry capabilities except 2.9, registry may be paper or electronic. A fully electronic registry may be the last capability to be implemented; however, to report capabilities as in place within this domain, the registry must be fully in place and routinely utilized.

Eleven of the Patient Registry capabilities identify the population of patients included in the registry (2.1, 2.10, 2.11, 2.12, 2.13, 2.15, 2.16, 2.17, 2.18, 2.22, and 2.23). The other twelve Patient Registry capabilities pertain to registry functionality (2.2, 2.3, 2.4, 2.5, 2.6., 2.7, 2.8, 2.9, 2.14, 2.19, 2.20, and 2.21). All capabilities pertaining to functionality that are marked as in place must be in place for each population of patients marked as "included" in the registry.

2.1
A paper or electronic all-payer registry is being used to manage all established patients in the Practice Unit with: Diabetes
(For specialists, relevant patient population selected for initial focus and not addressed in other 2.0 capabilities)

PCP Guidelines:

a. "Active use" is defined as using the key content of the registry to conduct outreach and proactively manage the patient population
    i Generating patient lists that are not being actively used to manage the patient population does not meet the intent of this capability
b. A patient registry is a database that enables population-level management in addition to generating point of care information, and allows providers to view patterns of care and gaps in care across their patient population. A registry contains several dimensions of clinical data on patients to enable providers to manage their population of patients.
c. Relevant clinical information that is the focus of attention in generally accepted guidelines, and is incorporated in common quality measures pertinent to the chronic illness, must be incorporated in the registry (i.e., physiologic parameters, lab results, medication use, physical findings, and patient behaviors such as peak flow meter use or daily salt intake).
d. Registry data must be in the form of data fields that are accessible for tabulation and population management.
e. Registry must include all established patients with the disease referenced in the capability, regardless of insurance coverage (including Medicare patients)
f. Patients assigned by managed care organizations do not have to be included in registry if they are not established patients (reference 2.15); however, outreach to those patients may be appropriate (reference 1.2 and 2.15)
g. Patient information may be entered by the practice, populated from EHR or other electronic or manual sources, or populated with payer-provided data
    i. Registry must include data pertinent to the clinical performance measures contained in the Clinical Quality Initiative (e.g., BCBSM-provided data or similar data from other sources)

h. Registry may initially be a component of EHR for basic-level functioning, as long as the practice or the PO has the capability to use the EHR to generate routine population-level performance reports and reports on subsets of patients requiring active management.
    i. Subsets of patients requiring active management refers to those patients with particular chronic illness management needs including but not limited to those who have physiologic parameters out of control, or who have not received specified, essential services
i. Reference AAFP article for additional information on creating a registry: http://www.aafp.org/fpm/2011/0500/p11.html

Specialist Guidelines:

a. Active use is defined as using the key content of the registry to conduct outreach and proactively manage the patient population
    i Generating patient lists that are not being actively used to manage the patient population does not meet the intent of this capability
b. A patient registry is a database that enables population-level management in addition to generating point of care information, and allows providers to view patterns of care and gaps in care across their patient population. A registry contains several dimensions of clinical data on patients to enable providers to manage and improve the health of their population of patients.
c. Relevant clinical information that is the focus of attention in generally accepted guidelines and is incorporated in common quality measures pertinent to the patient population must be incorporated in the registry (e.g., physiologic parameters, lab results, medication use, physical findings, and patient behaviors such as peak flow meter use or daily salt intake).
d. Registry data must be in the form of data fields that are accessible for tabulation and population management.
e. Registry must include all established patients for which the specialist has ongoing primary or co-management responsibility with the condition referenced in the capability, regardless of insurance coverage (including Medicare patients)
    i For ER physicians, a registry that tracks frequent ER users, or patients with drug-seeking behavior, may qualify
f. Patients assigned by managed care organizations do not have to be included in registry if they are not established patients (reference 2.15).
g. Patient information may be entered by the practice, populated from EHR or other electronic or manual sources, or populated with payer-provided data
    i Registry must include data pertinent to key clinical performance measures (e.g., BCBSM-provided data or similar data from other sources)
h. Registry may initially be a component of EHR for basic-level functioning, as long as the practice or the PO has the capability to use the EHR to generate routine population-level performance reports and reports on subsets of patients requiring active management.
    i Subsets of patients requiring active management refers to those patients with particular management needs including but not limited to those who have physiologic parameters out of control or who have not received specified, essential services
    ii For example, for behavioral health providers, i.e., psychologists and psychiatrists, common relevant conditions would be depression and anxiety
i. Reference article on creating a simple disease registry: http://www.aafp.org/fpm/20060400/47usin.html

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo the process of using the registry tool to identify the patient population • Registry should contain relevant clinical info • How is the info entered in the registry? • What do you do with it when you receive it, how do you address gaps in care?	

2.2

Registry incorporates patient clinical information, for all established patients in the registry, for a substantial majority of health care services <u>received at other sites</u> that are necessary to manage the population

<u>PCP Guidelines:</u>

a. Registry may be paper or electronic
b. "All patients in the registry" may consist, for example, of diabetes patients only, if practice unit has only implemented capability 2.1.
c. The registry is not expected to contain clinical information on all health care services received at any site for 100% of patients in the registry, but is expected to contain a critical mass of information from various sources, including the PO's or practice unit's own practice management system, and electronic or other records from facilities with which the PO or practice unit is affiliated
d. **Other sites and service types are defined as labs, inpatient admissions, ER, UCC, and pharmaceuticals** (with dates and diagnoses where applicable).
e. The definition of "substantial majority of health care services" is three-quarters of **preventive and chronic** condition management services rendered to patients.
f. If registry is paper, information may be extracted from records and recorded in registry manually, and must be in the form of an accessible data field for population level management of patients

<u>Specialist Guidelines:</u>

a. Registry may be paper or electronic
b. "All patients in the registry" may consist of patients relevant to the specialty type, if practice unit has only implemented capability 2.1.
c. The registry is not expected to contain clinical information on all health care services received at any site for 100% of patients in the registry, but is expected to contain a critical mass of information from various relevant sources, including the PO's or practice unit's own practice management system, and electronic or other records from facilities with which the PO or practice unit is affiliated
d. Other sites and service types are defined as labs, inpatient admissions, ER, urgent care and pharmaceuticals (with dates and diagnoses where applicable), when relevant to the condition being managed by the specialist,
e. The definition of "substantial majority of health care services" is three-quarters of relevant services rendered to patients.

f. If registry is paper, information may be extracted from records and recorded in registry manually, and must be in the form of an accessible data field for population level management of patients

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• What data elements are included in population registry? • At least 4 out of the 5 data elements from other sites (Lab, ED, IP, UC, Meds) must be in registry and/or patient record	

2.3
Registry incorporates evidence-based care guidelines

PCP and Specialist Guidelines:

a. Registry functionality may be paper or electronic.
b. Guidelines should be drawn from recognized, validated sources at the state or national level (e.g., MQIC Guidelines, USPSTF).
c. Determination of which evidence-based care guidelines to use should be based on judgment of practice leaders.

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Incorporates evidence-based care guidelines (MQIC, HEDIS) • Review data elements in registry to ensure evidence-based care guidelines are incorporated	

2.4
Registry information is available and in use by the Practice Unit team at the point of care

PCP and Specialist Guidelines:

a. Registry functionality may be paper or electronic.
b. Practice unit has and is fully using the capability to generate up-to-date, integrated individual patient reports at the point of care to be used during the visit.
c. EHR would meet the requirements of this capability provided it contains evidence-based guidelines, and relevant information is identified and imported into screens or reports that facilitate easy access to all relevant data elements particular to the conditions under management, for the purpose of guiding point of care services.

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Actively using at point of care • Ask about use of registry pre/during/post patient interaction in EMR or chart	

~~***2.5***~~

~~***Registry contains information on the individual practitioner for every patient currently in the registry who is an established patient in the practice unit***~~

RETIRED

~~*PCP Guidelines:*~~

~~a. Registry may be paper or electronic~~

~~b. The individual practitioner responsible for the care of each patient is identified in the registry~~

~~i. Occasional gaps in information about some patients' individual attributed practitioner due to changes in medical personnel are acceptable~~

~~*Specialist Guidelines:*~~

~~c. Registry may be paper or electronic~~

~~d. The individual practitioner responsible for the care of each patient is identified in the registry~~

2.6

Registry is being used to generate routine, systematic communication to patients regarding gaps in care

PCP and Specialist Guidelines:

a. Registry may be paper or electronic.
b. Communications may be manual, provided there is a systematic process in place and in use for generation of regular and timely communications to patients.
c. Communications may be sent to patients via email, fax, regular mail, text messaging, or phone messaging.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Used to identify gaps in care, communicated (mail, phone, email, portal) to patient • Demo use of registry to reach out to patients	

2.7

Registry is being used to flag gaps in care for every patient currently in the registry

PCP and Specialist Guidelines:

a. Registry may be paper or electronic.
b. Registry must have capability to identify all patients with gaps in care based on evidence-based guidelines incorporated in the registry.
c. EHR would meet the requirements of this capability if it can be used to produce population level information on gaps in care for chronic condition patients.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Used to flag gaps in care for all patients in registry	

• How are patients identified, missing tests, missed data elements

2.8
Registry incorporates information on patient demographics for all patients currently in the registry

PCP and Specialist Guidelines:

a. Registry may be paper or electronic.
b. Registry contains basic patient demographics, including name, gender, date of birth.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Contains all relevant patient demographics (name, gender, age, etc.) • Demonstrate evidence in registry	

2.9
Registry is fully electronic, comprehensive and integrated, with analytic capabilities

PCP and Specialist Guidelines:

a. Practice unit must have capability 2.2 in place in order to receive credit for 2.9
b. All data entities must flow electronically into the registry
c. Data is housed electronically
d. Linkages to other sources of information (as defined in 2.2) are electronic for all facilities and other health care providers with whom the practice unit regularly shares responsibility for health care.
e. Registry has population-level database and capability to electronically produce comprehensive analytic integrated reports that facilitate management of the entire population of the Practice Unit's patients.

Required for PCMH Designation: NO	**Predicate Logic: 2.2**
PCMH Validation Notes for Site Visits	
• Fully electronic - direct feed of labs, admits, ED • Demonstrate evidence in registry	

2.10
Registry is being used to manage all patients with: Persistent Asthma

PCP and Specialist Guidelines:

a. Reference 2.1(a)-(g).

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Demo the process of using the registry tool to identify the patient population • Registry should contain relevant clinical info • How is the info entered in the registry?	

• What do you do with it when you receive it, how do you address gaps in care?

2.11
Registry is being used to manage all patients with Coronary Artery Disease (CAD)

PCP and Specialist Guidelines:

b. Reference 2.1(a)-(g).

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo the process of using the registry tool to identify the patient population • Registry should contain relevant clinical info • How is the info entered in the registry? • What do you do with it when you receive it, how do you address gaps in care?	

2.12
Registry is being used to manage all patients with: Congestive Heart Failure (CHF)

PCP and Specialist Guidelines:

a. Reference 2.1(a)-(g).

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo the process of using the registry tool to identify the patient population • Registry should contain relevant clinical info • How is the info entered in the registry? • What do you do with it when you receive it, how do you address gaps in care?	

2.13
Registry includes at least 2 other conditions

PCP Guidelines:

a. Reference 2.1(a)-(g).
b. Registry includes at least 2 other **chronic conditions not addressed in other 2.0 capabilities** for which there are evidence-based guidelines and the need for ongoing population and patient management, and which are sufficiently prevalent in the practice to warrant inclusion in the registry based on the judgment of the practice leaders
    i Examples of other chronic conditions include (but are not limited to) depression in adults, sickle cell anemia, hypertension, anxiety

Specialist Guidelines:

a. Reference 2.1(a)-(g).
b. Registry is being used to manage all patients with at least 2 other conditions relevant to the specialist's practice for which there are evidence-based guidelines and the need for ongoing

population and patient management, and which are sufficiently prevalent in the practice to warrant inclusion in the registry based on the judgment of the practice leaders

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo the process of using the registry tool to identify the patient population • Registry should contain relevant clinical info • How is the info entered in the registry? • What do you do with it when you receive it, how do you address gaps in care? • Note: Remember the two conditions must be different than those listed in previous capabilities	

2.14

Registry incorporates preventive services guidelines and is being used to generate routine, systematic communication to all patients in the practice regarding needed preventive services

PCP Guidelines:

a. Reference 2.1(a)-(g).
b. Registry must include all current patients in the practice, including well patients, regardless of insurance coverage and including Medicare patients
c. Preventive services guidelines must be drawn from a recognized state or national source, such as USPSTF, CDC, or national guidelines that address standard primary and secondary preventive services (i.e., mammograms, cervical cancer screenings, colorectal screening, immunizations, well-child visits, well-adolescent visits, and well-adult visits).

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Incorporates preventive services (mammograms, pap smears, immunizations, well visits) & outreach to engage them in practice.	

2.15

Registry incorporates patients who are assigned by managed care plans once they are established patients in the practice

PCP Guidelines:

a. Active outreach should be conducted to engage patients assigned by managed care plans
b. Patients assigned by managed care plans should be included in the registry once they are established in the practice

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Patients do not need to be added to registry until they are established with practice; if practice can demonstrate active outreach to the assigned-but-not-established patients, this capability can be marked as in place.	

2.16

Registry is being used to manage all patients with: Chronic Kidney Disease

PCP and Specialist Guidelines:

a. Reference 2.1(a)-(g).

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo the process of using the registry tool to identify the patient population • Registry should contain relevant clinical info • How is the info entered in the registry? • What do you do with it when you receive it, how do you address gaps in care?	

2.17

Registry is being used to manage all patients with: Pediatric Obesity

PCP and Specialist Guidelines:

a. Reference 2.1(a)-(g).

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo the process of using the registry tool to identify the patient population • Registry should contain relevant clinical info • How is the info entered in the registry? • What do you do with it when you receive it, how do you address gaps in care?	

2.18

Registry is being used to manage all patients with: Pediatric ADD/ADHD

PCP and Specialist Guidelines:

a. Reference 2.1(a)-(g).

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo the process of using the registry tool to identify the patient population • Registry should contain relevant clinical info • How is the info entered in the registry? • What do you do with it when you receive it, how do you address gaps in care?	

2.19

Registry contains information identifying the individual care manager for every patient currently in the registry who has an assigned care manager

PCP and Specialist Guidelines:

a. Registry may be paper or electronic

b. Registry includes name of the care manager for each patient with an assigned care manager
c. Where a patient has more than one care manager, registry must identify which care manager is the lead care manager

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Registry includes name of care manager for each patient with an assigned care manager	

2.20

Registry contains advanced patient information that will allow the practice to identify and address disparities in care

PCP and Specialist Guidelines:

a. Registry may be paper or electronic.
    i. Registry contains advanced patient demographics to enable practices to identify vulnerable patient populations, including race and ethnicity, and including data elements such as:
        1. primary/preferred language
        2. measures of social support (e.g., caretaker for disability, family network)
        3. disability status
        4. health literacy limitations
        5. type of payer (e.g., uninsured, Medicaid)
        6. relevant behavioral health information (e.g., date of depression screening and result)
        7. social determinants of health such as housing instability, transportation limitations, food insufficiency, risk of exposure to violence

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Registry contains relevant advanced patient demographics, as listed in the guidelines (at least four of the seven elements).	

2.21

Registry contains additional advanced patient information that will allow the practice to identify and address disparities in care

PCP and Specialist Guidelines:

b. Registry may be paper or electronic.
    ii. Registry contains advanced patient demographics to enable them to identify vulnerable patient populations, including both:
        1. gender identity
        2. sexual orientation

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Registry contains advanced patient demographics, as listed in the guidelines	

2.22

Registry is being used to manage all patients with: Pediatric autism

PCP and Specialist Guidelines:

a. Reference 2.1(a)-(g).
b. Information about screening tools for autism is available here: https://www.cdc.gov/ncbddd/autism/hcp-screening.html

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo the process of using the registry tool to identify the patient population • Registry should contain relevant clinical info such as which screening tool was used to identify condition and related results from screening, along with next steps/treatment plan which may include, but is not limited to, speech therapy, occupational therapy, etc. • How is the info entered in the registry? • What do you do with it when you receive it, how do you address gaps in care?	

2.23

Registry is being used to manage pediatric behavioral health disorders, which may include depression, anxiety, and/or eating disorders

PCP and Specialist Guidelines:

a. Reference 2.1(a)-(g).
b. If currently using depression for capability 2.13, a different condition other than depression must be used for this capability
c. Examples of behavioral health screening tools include the PHQ2/9, Postpartum Depression Screening and GAD (Generalized Anxiety Disorder) scale

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo the process of using the registry tool to identify the patient population • Registry should contain relevant clinical info such as which screening tool was used to identify condition and related results from screening, along with next steps/treatment plan • How is the info entered in the registry? • What do you do with it when you receive it, how do you address gaps in care?	

c. Reference 3.1

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• The practice must demo how they are using these performance reports to improve population management. • Steps: 1) For each chronic condition, are the relevant measures included in the performance reports? 2) What sort of review is being done with these reports? 3) What actions are taken?	

4.0 Individual Care Management

Goal: Patients receive organized, planned care that empowers them to take greater responsibility for their health

28 total capabilities; 1 required
All capabilities applicable to: Adult and Peds patients

Applicable to PCPs and specialists (specialist practice must have lead responsibility for care management for at least a subset of patients for a period of time; e.g., oncology care manager has lead responsibility for patients when they are in active chemotherapy). For patients with an ongoing care relationship with a specialist, PCP and specialist must establish agreement regarding who will have lead responsibility for care management.

To receive credit for an individual care management capability, basic care management delivered in the context of office visits must be available to all patients. Advanced care management, delivered by trained care managers in the context of provider-delivered care management services, is expected to be available only to those members who have the provider-delivered care management benefit.

To facilitate phased implementation of capabilities, providers may select a subset of their patient population for initial focus for capabilities 4.2, 4.5, 4.6, 4.7, 4.8, and 4.9

4.1
Practice Unit leaders and staff have been trained/educated and have comprehensive knowledge of the Patient-Centered Medical Home and Patient Centered Medical Home-Neighbor models, the Chronic Care model, and practice transformation concepts

PCP Guidelines:

a. Training content should include comprehensive information about the Chronic Care Model
   i. Reference information provided at the Improving Chronic Illness Care website: http://www.improvingchroniccare.org
b. Training/educational activity is documented in personnel or training records, and content material used for training is available for review.

a. Training occurs at time of hire for new staff, and is repeated at least annually for all staff.
c. Process is in place to ensure all staff are apprised of changes in the PCMH/PCMH-N. Interpretive Guidelines, and of the capabilities that have been implemented by the practice.

Specialist Guidelines:

a. Training content should include comprehensive information about the Chronic Care Model and population management, and its relevance to specialists.
    i. Reference information provided at the Improving Chronic Illness Care website: http://www.improvingchroniccare.org
b. Training/educational activity is documented in personnel or training records, and content material used for training is available for review.
c. Process is in place to ensure new staff receive training.
d. Process is in place to ensure all staff are kept apprised of changes in the PCMH/PCMH-N Interpretive Guidelines, and of the capabilities that have been implemented by the practice.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Current Documentation Required • All staff trained on PCMH, chronic care model and practice transformation (sign-in staff sheet) • Discuss process of training, review educational materials used & documentation of training • Training related material in manual acceptable as demo, review dates of training	

4.2

Practice Unit has developed an integrated team of multi-disciplinary providers and a systematic approach is in place to deliver coordinated care management services that address patients' full range of health care needs for the patient population selected for initial focus

PCP and Specialist Guidelines:

a. The integrated team of multi-disciplinary providers must consist of at least 3 non-physician members, including at least 3 of the following (composition of team may vary depending on the needs of individual patients): Registered nurse, Certified diabetes educator, nutritionist (RD or Masters-trained nutritionist), respiratory therapist, PharmD or RPH, MSW, certified asthma health educator or other certified health educator specialist (Bachelor's degree or higher in Health Education), licensed professional counselor, licensed mental health counselor, or an NP and/or PA with training/experience in health education who is actively engaged in care coordination/self-management training separate from their office visit E&M duties
    i. When they are unable to include RNs or PharmDs in the multi-disciplinary care management team, individual practices may use LPNs or PharmD students, in which case these ancillary providers with lesser training must be actively supervised by the physician and/or by a supervising RN or PharmD, with regard to the educational and care management interventions provided to each individual patient. This

supervision must be provided either directly in the practice (e.g., by the primary care physician) or by staff employed by the Physician Organization.

b. Practice unit team members hold regular team meetings and/or other structured communications about patients whose conditions are being actively managed.
c. All members of the team do not have to be at the same location or at the practice site, but care delivered by the team must be coordinated and integrated with the practice.
    i. When care is delivered by travel teams or at sites other than the practice:
        - The care must be fully coordinated by a practice team member or a health navigator who has ongoing communication with the practice
        - The PCMH/PCMH-N practice must be involved in ongoing monitoring, follow-up and reinforcement of health education/training received by patients at other sites
            - Monitoring includes proactive outreach to engage the patient in actively addressing ongoing health needs and health care goals on a longitudinal basis
    ii. The multi-disciplinary providers are not required to be employees of the PCMH/PCMH-N practice, but must have an ongoing relationship with, and communication with, the practice team members
        - Communication can be a combination of verbal, written, and electronic methods, preferably including some direct verbal communication and participation in in-person team meetings, although individual team members who are not on-site at a practice can make their information and perspective known to specific team members so that their information about individual patients is actively considered by the team as a routine part of case review and planning
    iii. The care management services must be coordinated and integrated with the patient's overall care plan
        - The requirements for capability 4.2 can be met through referrals to hospital-based diabetes educators that take place in the context of an overall coordinated, integrated care plan and include bi-lateral communication between the diabetes educator and care management team, with individualized feedback provided to the care team following the diabetes education sessions. Diabetes educator and care team collaborate to ensure that referred patients receive needed services, and that patients understand that they should follow-up with PCMH practice regarding questions and concerns.
        - Standard referrals to hospital-based diabetes educators with summary reports sent back to the PCP do not constitute care that is coordinated and integrated, and would not meet the requirements for capability 4.2

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Multidisciplinary team (include RN, DM educators, etc.), regular team meetings, travel teams, ongoing communication w/ PU • Office describes team and condition addressed • Must be a multi-disciplinary team (min of 3). Examples of structured communication between team members at planned intervals.	

4.3

Systematic approach is in place to ensure that evidence-based care guidelines are established and in use at the point of care by all team members of the Practice Unit

PCP Guidelines:

a. Guidelines are available and used at the point of care by all clinical staff in the Practice Unit
    i. Guidelines are activated and used regularly to provide alerts about gaps in care on the Point of Care report or in the EHR
b. All members in the practice, including front office staff who work with clinicians and patients, are knowledgeable about the type and length of appointments to book and their responsibilities for preparing resources for visits, based on the guidelines
    i. Guidelines are actively used to monitor, track, and conduct outreach to patients to schedule care as needed
c. Guidelines are used by PO to evaluate performance of physicians, Practice Units, and PO.

Specialist Guidelines:

a. Evidence-based care guidelines may be those developed by specialist societies
b. Guidelines are available and used at the point of care by all clinical staff in the Practice Unit
    i. Guidelines are activated and used regularly to provide alerts about gaps in care on the Point of Care report or in the EHR
c. All members in the practice, including front office staff who work with clinicians and patients, are knowledgeable about the type and length of appointments to book and their responsibilities for preparing resources for visits, based on the guidelines
    i. Guidelines are actively used to monitor, track, and conduct outreach to patients to schedule care as needed
d. Guidelines are used by PO to evaluate performance of physicians, Practice Units, and PO.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Evidence based care guidelines are used at point of care, flags gaps in care, guidelines assist with appointment time booking • Have clinical staff demonstrate linking of evidence-based guidelines to upcoming patient visits	

4.4

PCMH/PCMH-N patient satisfaction/office efficiency measures are systematically administered

PCP Guidelines:

a. Patient satisfaction and office efficiency measures (e.g., patient waiting time to obtain appointment, office visit cycle time, percentage of no-show appointments) are monitored on an ongoing basis
    i. Measures must be derived from surveys conducted by the office or from information provided by health plans, the PO, or other sources
        - Surveys do not need to focus on a specific chronic condition, provided they capture information relevant to all chronic conditions, such as asking about

whether the primary practitioner discusses health care goals, diet and exercise, and supports the patient in achieving health management goals
        - Surveys should be conducted annually at minimum
    ii. Reference information at Agency for Healthcare Research and Quality about CAHPS: http://www.ahrq.gov/cahps/index.html
    iii. Results must be quantified, aggregated, and tracked over time
b. If office is not meeting standards for patient-centered care, follow-up occurs (e.g., process improvements are implemented; efficiencies are improved; practice culture is addressed)

Specialist Guidelines:

a. Patient satisfaction and office efficiency measures (e.g., patient waiting time to obtain appointment, office visit cycle time, percentage of no-show appointments) are monitored
    i. Measures must be derived from surveys conducted by the office or from information provided by health plans, the PO, or other sources
    ii. Surveys should capture information relevant to all patients managed by the specialist
    iii. Reference information at Agency for Healthcare Research and Quality about CAHPS: http://www.ahrq.gov/cahps/index.html
    iv. Results must be quantified, aggregated, and tracked over time
b. If office is not meeting standards for patient-centered care, follow-up occurs (e.g., process improvements are implemented; efficiencies are improved; practice culture is addressed)

[Please see Patient Registry** and **Performance Reporting Initiatives for clinical monitoring expectations]

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Patient survey re: office efficiency results are quantified, aggregated, and tracked over time	

4.5

Development and incorporation into the medical record of written action plan and goal-setting is systematically offered to the patient population selected for initial focus, with substantive patient-specific and patient-friendly documentation provided to the patient

PCP and Specialist Guidelines:

a. Physicians and other practice team members are actively involved in working with patients to use goal-setting techniques and develop action plans
    i. Goal-setting should focus on specific changes in behavior (e.g., walking around the block once a day) or concrete, tangible results (e.g., losing 2 pounds) rather than general clinical goals (such as lowering blood pressure or reducing LDL levels)
b. Patient-specific action plan and patient's individual goals must be documented in medical record, enabling providers to monitor and follow-up with patient during subsequent visits
c. Reference information provided at the Improving Chronic Illness Care website: http://www.improvingchroniccare.org/index.php?p=self-management_support&s=39

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	

• Example required • Written action plans & goal setting (patient-specific) for 1 chronic condition • Provide real time examples of patient action plans from patients in the registry.

4.6- Required

A systematic approach is in place for appointment tracking and generation of reminders for the patient population selected for initial focus

PCP and Specialist Guidelines:

a. Evidence-based guidelines are used systematically as a basis for:
    i. Conducting tracking and follow-up regarding missed appointments
    ii. Providing patients with mail and/or telephone reminders of upcoming appointments

Required for PCMH Designation: YES	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Appointment reminder (upcoming appts) & tracking (no shows) for 1 chronic condition • Discuss appointment tracking process - follow up for no shows, demo recent example	

4.7

A systematic approach is in place to ensure that follow-up for needed services is provided for the patient population selected for initial focus

PCP and Specialist Guidelines:

a. Evidence-based guidelines are used systematically as a basis for:
    i. Following up with patients to ensure that needed services, whether at the PCMH/PCMH-N practice site or at another care site, are obtained by the patients

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• System to ensure follow up for needed services for one chronic condition • Discuss process for follow up in general. Demonstrate recent example. • Recall system for patients that are not seen?	

4.8

Planned visits are offered to the patient population selected for initial focus

PCP and Specialist Guidelines:

a. Planned visits consist of a documented, proactive, comprehensive approach to ensure that patients receive needed care in an efficient and effective manner.
    i. Planned visits include the well-orchestrated, team-based approach to managing the patient's care during the visit, performed on a routine basis, as well as the tracking

and scheduling of regular visits, and the guideline-based preparation that occurs prior to the visit.

b. Many healthcare providers believe themselves to already be doing 'planned' visits. They note that their patients with chronic conditions come back at defined intervals. Yet upon closer inspection, these visits may look a lot like acute care: the provider might lack necessary information about the patient's care needs; provider and patient might have different expectations for the visit; and staff may not be fully utilized to help with the organization of the visit and delivery of care. These 'check-back' visits, while scheduled in advance, are often not efficient or productive for the provider and patient.

c. Key Components of a Planned Visit
    i. Assign Team Roles and Responsibilities
        - For example, the following questions might need to be addressed: who is going to call the patient to schedule the visit? Who will room the patient? If the patient has diabetes, who will remove her/his shoes and socks? Who will examine the feet? Who will prepare the patient encounter form for use during the visit? All tasks need to be delegated to specific team members so that nothing is left to chance.
    ii. Call a Patient in For a Visit
        - Develop a script for the call, and then decide which team member will make the call. Set the tone and expectations for the issues addressed in the visit.
        - If you choose to mail an invitation to patients, be sure to track respondents. Typically, less than 50% of patients respond to a letter. You will need to plan an alternative method of contacting non-responders.
    iii. Deliver Clinical Care and Self-Management Support
        - In preparation for the visit, print an encounter form from your registry or pull the chart in advance so that you can review the patient's care to date. Document what clinical care needs to be done during the visit.
    iv. Until new roles are well integrated into the normal work flow, many practices have team huddles for 5-10 minutes…to review the schedule and identify chronic care patients coming in that day for an acute care visit. Decide how best to meet as a team to manage these patients. Determine the best intervals and timing for these meetings and stick to them. The brief get-togethers help the team stay focused on practice redesign and create a spirit of 'one for all'.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Documented process required. Planned visit - proactive, team approach to manage care during visit for one condition. Identify team roles (who calls patients), encounter forms printed and on chart prior to visit, and team huddles • Pick patient, have staff walk through what they do for a planned visit, look for evidence of evidence-based interventions. Provide documented process/guideline for planned visit with roles identified for practice unit staff. Show example of recent planned visit in schedule.	

4.9
Group visit option is available for the patient population selected for initial focus (as appropriate for the patient)

PCP and Specialist Guidelines:

a. Reference AAFP information on group visits at: http://www.aafp.org/fpm/20060100/37grou.html
b. Group visits are a form of office visit. (They are not the same as care coordination/care management services, which are follow-up services delivered by non-physician clinicians antecedent to an office visit at which individual treatment and/or health behavior goals have been established.)
c. Group visits include not only group education and interaction but also all essential elements of an individual patient visit, including but not limited to the collection of vital signs, history taking, relevant physical examination and clinical decision-making.
    i. Group visits differ from other forms of group interventions, such as support groups, which are generally led by peers and do not include one-on-one consultations with physicians.
d. The clinician is directly involved and meets with each patient individually
    i. NP or PA may conduct both the clinical and educational/group activity components of the group visit
e. Members of the care management team may take vital signs and other measurements and assist with individual encounters
f. Dietitians or pharmacists may lead educational sessions. Topics such as medication management, stress management, exercise and nutrition, and community resources, may be suggested by the group facilitator or by patients, who raise concerns, share information and ask questions. In programs emphasizing self-management, physicians and patients work together to create behavior-change action plans, which detail achievable and behavior-specific goals that participants aim to accomplish by the next session. Once plans are set, the group discusses ways to overcome potential obstacles, which raises patients' self-efficacy and commitment to behavioral change. Patients' family members can also be included in these group sessions."
g. Group visits generally last from two to 2.5 hours and include no more than 20 patients at a time.
h. Group visits may be conducted in collaboration with other Practice Units

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Group visit (2 hrs, no more than 20 pts), must include 1 on 1 with clinical decision-maker. Discuss patient selection process, walk through group visit: Who attended the group visit? How did practice reach out to patients? Can practice identify group visits now occurring?	

4.10
Medication review and management is provided at every visit for all patients with conditions requiring management

PCP Guidelines:

a. At a minimum, medication review and management are provided by clinical decision-maker at every visit for all patients with chronic conditions.
    i. Chronic conditions under 4.10 are defined as any condition requiring maintenance drug therapy.
    ii. During every patient encounter, a list of all medications currently taken by the patient is reviewed and updated, and any concerns regarding medication interactions or side effects are addressed.
        - Adjustments are made during every encounter to ensure list is current and matches current clinical needs, and any medication discrepancies or contraindications are resolved by a clinician

Specialist Guidelines:

a. At a minimum, medication review and management are provided at every visit for all patients with chronic conditions or when indicated given the patient's health status
    i. Chronic conditions under 4.10 are defined as any condition requiring maintenance drug therapy.
    ii. During every patient encounter, a list of all medications currently taken by the patient is reviewed and updated, and any concerns regarding medication interactions or side effects are addressed.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Walk through medication reconciliation for patient scheduled to appear in office	

4.11

Development and incorporation into medical record of written action plans and goal-setting is systematically offered to all patients with chronic conditions or other complex health care needs prevalent in practice's patient population

PCP and Specialist Guidelines:

a. Reference 4.5

Required for PCMH Designation: NO	**Predicate Logic: 4.5**

4.12

A systematic approach is in place for appointment tracking and generation of reminders for all patients

PCP and Specialist Guidelines:

b. Evidence-based guidelines are used systematically as a basis for:
    i. Conducting tracking and follow-up regarding missed appointments
    ii. Providing patients with mail and/or telephone reminders of upcoming appointments

Required for PCMH Designation: NO	Predicate Logic: 4.6
PCMH Validation Notes for Site Visits	
• Appointment tracking and reminder for ALL pts	

4.13

A systematic approach is in place to ensure follow-up for needed services for all patients

PCP and Specialist Guidelines:

c. Evidence-based guidelines are used systematically as a basis for:
    i. Following up with patients to ensure that needed services, whether at the PCMH/PCMH-N practice site or at another care site, are obtained by the patients

Required for PCMH Designation: NO	Predicate Logic: 4.7
PCMH Validation Notes for Site Visits	
• System to ensure follow up for needed services for all patients	

4.14

Planned visits are offered to all patients with chronic conditions (or, for some specialists, all sub-acute conditions) prevalent in practice population

PCP and Specialist Guidelines:

d. Planned visits consist of a documented, proactive, comprehensive approach to ensure that patients receive needed care in an efficient and effective manner.
    i. Planned visits include the well-orchestrated, team-based approach to managing the patient's care during the visit, performed on a routine basis, as well as the tracking and scheduling of regular visits, and the guideline-based preparation that occurs prior to the visit.

e. Many healthcare providers believe themselves to already be doing 'planned' visits. They note that their patients with chronic conditions come back at defined intervals. Yet upon closer inspection, these visits may look a lot like acute care: the provider might lack necessary information about the patient's care needs; provider and patient might have different expectations for the visit; and staff may not be fully utilized to help with the organization of the visit and delivery of care. These 'check-back' visits, while scheduled in advance, are often not efficient or productive for the provider and patient.

f. Key Components of a Planned Visit
    i. Assign Team Roles and Responsibilities
        - For example, the following questions might need to be addressed: who is going to call the patient to schedule the visit? Who will room the patient? If the patient has diabetes, who will remove her/his shoes and socks? Who will examine the feet? Who will prepare the patient encounter form for use during the visit? All tasks need to be delegated to specific team members so that nothing is left to chance.
    ii. Call a Patient in For a Visit

- Develop a script for the call and then decide which team member will make the call. Set the tone and expectations for the issues addressed in the visit.
- If you choose to mail an invitation to patients, be sure to track respondents. Typically, less than 50% of patients respond to a letter. You will need to plan an alternative method of contacting non-responders.

iii. Deliver Clinical Care and Self-Management Support
- In preparation for the visit, print an encounter form from your registry or pull the chart in advance so that you can review the patient's care to date. Document what clinical care needs to be done during the visit.

iv. Until new roles are well integrated into the normal work flow, many practices have team huddles for 5-10 minutes…to review the schedule and identify chronic care patients coming in that day for an acute care visit. Decide how best to meet as a team to manage these patients. Determine the best intervals and timing for these meetings and stick to them. The brief get-togethers help the team stay focused on practice redesign and create a spirit of 'one for all'.

Required for PCMH Designation: NO	**Predicate Logic: 4.8**
PCMH Validation Notes for Site Visits	
• Documented process required. Planned visits for ALL patients w/ chronic conditions	

4.15

Group visit option is available to all patients with chronic conditions (or, for some specialists, all sub-acute conditions) prevalent in practice population

PCP and Specialist Guidelines:

g. Reference AAFP information on group visits at: http://www.aafp.org/fpm/20060100/37grou.html
h. Group visits are a form of office visit. (They are not the same as care coordination/care management services, which are follow-up services delivered by non-physician clinicians antecedent to an office visit at which individual treatment and/or health behavior goals have been established.)
i. Group visits include not only group education and interaction but also all essential elements of an individual patient visit, including but not limited to the collection of vital signs, history taking, relevant physical examination and clinical decision-making.
    i. Group visits differ from other forms of group interventions, such as support groups, which are generally led by peers and do not include one-on-one consultations with physicians.
j. The clinician is directly involved and meets with each patient individually
    i. NP or PA may conduct both the clinical and educational/group activity components of the group visit
k. Members of the care management team may take vital signs and other measurements and assist with individual encounters
l. Dietitians or pharmacists may lead educational sessions. Topics such as medication management, stress management, exercise and nutrition, and community resources, may be suggested by the group facilitator or by patients, who raise concerns, share information and ask questions. In programs emphasizing self-management, physicians and patients work

together to create behavior-change action plans, which detail achievable and behavior-specific goals that participants aim to accomplish by the next session. Once plans are set, the group discusses ways to overcome potential obstacles, which raises patients' self-efficacy and commitment to behavioral change. Patients' family members can also be included in these group sessions."

m. Group visits generally last from two to 2.5 hours and include no more than 20 patients at a time.
n. Group visits may be conducted in collaboration with other Practice Units

Required for PCMH Designation: NO	Predicate Logic: 4.9
PCMH Validation Notes for Site Visits	
• Group visit (2 hrs, no more than 20 pts), must include 1 on 1 with MD/NP/PA • Discuss patient selection process, walk through group visit: Who attended the group visit? How did practice reach out to patients? Can practice identify group visits now occurring?	

4.16

A systematic approach is in place for tracking patients' use of advance care plans, including engaging patients in conversation about advance care planning, executing an advance care plan with each patient who wishes to do so and including a copy of a signed advance care plan in the patient's medical record, and where appropriate conducting periodic follow-up conversations with patients who have not yet executed an advance care plan

PCP Guidelines:

a. PCP must have systematic process in place to communicate with specialists and identify who has lead responsibility for discussing and assisting each patient with advance care planning
    i. Training and information about advance care planning is available from the Centers for Disease Control and through a number of healthcare organizations
b. PCP must have systematic process in place to track care plans distributed to patients and returned to PCP, and where appropriate, to conduct periodic follow-up conversations with patients who have not yet executed an advance care plan
c. If patient is not ready to sign an advance care plan, document in medical record and address at next health maintenance exam

Specialist Guidelines:

a. Specialist(s) must have systematic process in place to communicate with PCP and identify who has lead responsibility for discussing and assisting each patient with advance care planning
    i. Specialists are not expected to engage in advance care planning with patients visiting for routine, basic care
    ii. Training and information about advance care planning is available from the Centers for Disease Control and through a number of healthcare organizations
d. Specialist must have systematic process in place to track care plans distributed to patients and returned to specialist, and where appropriate, to conduct periodic follow-up conversations with patients who have not yet executed an advance care plan

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Advance Care Planning; conversation with patients, documentation, and demonstration of follow-up to patients who have been given advance care planning but have not returned paperwork. • Ask about who has conversation with patient. Does office have a template? If not the lead (specialist is) how are you informed of this? Specialist conversation? Sharing w/ PCP?	

4.17

A systematic approach is in place for developing a survivorship plan for patients once treatment is completed, including a copy of the survivorship plan in the patient's medical record, and ensuring that the plan is shared with the patient and the patient's providers

PCP and Specialist Guidelines:

a. PCP and specialist(s) must have systematic process in place to identify who has lead responsibility for developing each patient's individualized patient survivorship care plan that includes guidelines for monitoring and maintaining the health of patients who have completed treatment
    i. Information about survivorship plans can be accessed at: http://www.cancer.org/Treatment/SurvivorshipDuringandAfterTreatment/SurvivorshipCarePlans/index
b. Provider with lead responsibility must ensure that key care partners are aware of and have copies of the survivorship care plan

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Survivorship Plan; process in place once treatment is complete, documentation in chart, plan shared amongst patient's providers. • Does office have Survivorship Plan population? Who has conversation with patient - if not the lead (specialist is), how is practice informed of this? Has there been conversation with specialist?	

4.18

A systematic approach is in place for assessing patient palliative care needs and ensuring patients receive needed palliative care services

PCP and Specialist Guidelines:

a. PCP and specialists have systematic processes to identify patients who may have unmet needs related to serious illness. Potential identification triggers may include for example:
    i. Diagnosis or progression of serious illness such as advanced cancer, heart failure, COPD, or dementia
    ii. Multiple chronic illnesses with frequent hospitalizations
    iii. Significant scoring on risk stratification tools (e.g. LACE, PRISM, etc.)
    iv. Answer of "no" to the 'surprise' question: Would you be surprised if this patient were to die in the next year?

b. PCP and specialist(s) have systematic process in place to identify who has lead responsibility for assessing and addressing the palliative care needs of patients with serious illness, and referring to other providers as appropriate, including for example:
    i. Advance care planning (including Durable Power of Attorney-HC designation, discussion and documentation of patient values and preferences)
    ii. Pain and physical symptom management
    iii. Psychological and emotional symptoms
    iv. Spiritual distress
    v. Caregiver stress
    vi. Home or community-based support services
    vii. Hospice eligibility
c. Provider with lead responsibility ensures that all care partners are aware that patient is receiving palliative care services
d. Palliative care services are made available as needed to patients with unmet needs at all stages of seriously illness, not only at time of terminal diagnosis
e. Reference https://www.nationalcoalitionhpc.org/ncp-guidelines-2013 for definition of palliative care, and an overview of the domains that should be addressed in the delivery of comprehensive palliative care
f. Practice has established written protocols for determining when patients should be assessed for palliative care needs, based on accepted standards relevant to their patient population. Tools that can be used to support assessment and management of palliative care needs are available here:
    i. Advance care planning: www.prepareforyourcare.org (available in multiple languages); www.makingyourwishesknown.com
    ii. Prognosis: http://eprognosis.ucsf.edu/
    iii. Hospice eligibility: http://geriatrics.uthscsa.edu/tools/Hospice_elegibility_card__Ross_and_Sanchez_Reilly_2008.pdf;
g. Options for delivery of palliative care include:
    i. Delivery within practice: At least one member of practice has received training through established palliative care training program and has educated other practice staff. Examples of such training include:
        a) Hospice and Palliative Medicine Board Physician Certification (MD/DO)
        b) Hospice Medical Director Physician Certification (MD/DO)
        c) Palliative Care education for chaplaincy, nurses, social workers, and other health professionals: https://csupalliativecare.org/programs/
        d) For domains that cannot be addressed directly by practice staff, practice has knowledge of community resources that will enable patient to receive palliative care across all domains (e.g., physical, emotional, spiritual, legal, ethical).
    ii. Referrals: Practice maintains information on availability of comprehensive palliative care teams and makes referrals as appropriate. Sources for referral can be found at http://www.mihospice.org/

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Documentation required	

• Palliative Care; assessment process in place & shared among all care providers (including specialist) • Does office have Palliative Care population? If not the lead (specialist is), how is practice informed? • Has there been conversation with specialist?

4.19

Systematic process is in place to identify patients who would benefit from care management services based on clinical conditions and ED, inpatient, and other service use

PCP and Specialist Guidelines:

a. PCP and specialists must have systematic process in place to identify patients who are candidates for care management, and to document the results of the identification process
    i. PCPs should notify specialists when patient has care manager
    ii. Specialists should notify PCPs when specialist has care manager
    iii. When there is more than one care manager, the involved providers should coordinate to identify care manager with lead responsibility

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• PCP and SCP should notify provider if patient has a care manager- and identify the lead care manager if there are multiple	

4.20

Systematic process is in place to inform patients about availability of care management services

PCP and Specialist Guidelines:

a. PCP and specialist(s) must have systematic process in place to inform patients, family members, and caregivers about availability of care management services, and to document the conversation and the patient, family member, or caregiver response.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Documentation of patient conversation regarding care management services	

4.21

Multi-disciplinary team meetings are held regularly to conduct patient case reviews, with development and review of comprehensive care plans for medically complex patients

PCP and Specialist Guidelines:

a. PCP and specialist(s) must have systematic process in place to conduct and document regular patient case reviews, and develop and review comprehensive care plans for medically complex patients
b. Common elements of a comprehensive care management plan include:

i. Full problem list
ii. Expected outcome and prognosis
iii. Measurable treatment goals
iv. Symptom management
v. Planned interventions
vi. Medication management
    - Medication allergies
vii. Community/social services ordered
viii. Plan for directing/coordinating the services of agencies and specialists which are not connected to the practice
ix. Identify individual who is responsible for each intervention

Required for PCMH Designation: NO	Predicate Logic: 4.2
PCMH Validation Notes for Site Visits	
• Documentation of case review	

4.22

Provider initiating advance care plan in 4.16 ensures that all care partners are aware of and have copies of advance care plan

PCP and Specialist Guidelines:

a. Provider with lead responsibility must ensure that all care partners are aware of and have copies of advance care plan
b. When all practitioners are on a common EHR platform, there must be a systematic approach such as a flag or other notification mechanism to ensure all providers are aware that an advance care plan is in place

Required for PCMH Designation: NO	Predicate Logic: 4.16
PCMH Validation Notes for Site Visits	
• Documentation that ACP was shared with care partners or systematic way to flag in EHR	

4.23

Practice has engaged in root cause analysis of any areas where there are significant opportunities for improvement in patient experience of care using tested methods such as Journey Mapping or LEAN techniques

PCP and Specialist Guidelines:

a. Practice is currently or has within the past two years engaged in analysis of patient experience of care, using established methods such as Journey Mapping or LEAN
b. Steps to address areas of concern or dissatisfaction have been identified.

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Who is on the team	

- ID Problem - Current state vs. target (future) goal
- What kind of quality improvement has practice implemented? LEAN - PDCA? JM?
- What/How is this measured
- Test of change? Outcome?

4.24

Physician organization and/or practice unit standardizes, develops and maintains care management processes and workflows, to ensure efficient delivery of care management services in the practices for whom they coordinate/administer care management.

PCP and Specialist Guidelines:

a. This capability should be marked as "in-place" only for practices with whom the PO has worked to implement care management. Practice participation in care management may be verified using PDCM claims data.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• PO or practice provides documentation about general policies related to care management delivery and examples of care management workflows	

4.25

Physician organization ensures that care managers are trained, onboarded, and integrated into their practice(s) effectively. Includes ensuring training requirements are completed, creating process for "warm handoffs" from physician to care manager to facilitate strong uptake of care management services by patients, as well as development of communication materials to promote care manager as integral part of practice staff (i.e., flier about care manager role, business cards for care manager).

PCP and Specialist Guidelines:

a. This capability should be marked as "in-place" only for practices with whom the PO has worked to implement care management. Practice participation in care management may be verified using PDCM claims data.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• PO provides documentation on care manager training materials, care management training trackers, processes for ensuring warm handoffs, and/or practice materials used to introduce care manager to patients and caregivers	

4.26

Physician organization supports care management billing process for practices engaged in care management. PO may assist practice billing/coding staff with understanding care

management billing process, and ensuring the appropriate training resources are utilized for billing.

PCP and Specialist Guidelines:

a. This capability should be marked as "in-place" only for practices with whom the PO has worked to implement care management. Practice participation in care management may be verified using PDCM claims data.

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• PO or practice provides care management billing training/reference materials/job aids • PO or practice demonstrates billing of care management codes	

4.27

Physician organization assists practices with integrating and analyzing data related to effective care management, including the PDCM monthly member lists, and reports for tracking PDCM Engagement Initiative, to ensure optimal care management engagement and targeting.

PCP and Specialist Guidelines:

a. This capability should be marked as "in-place" only for practices with whom the PO has worked to implement care management. Practice participation in care management may be verified using PDCM claims data.

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• PO demonstrates procedure for processing/disseminating care management data to practices, including monthly patient lists and routine engagement reports and routine claims reports verified through health plan claims data • PO demonstrates how they assist practices in targeting high-risk patients	

4.28

Physician organizations assist practices with seeking waiver for offering Medication Assisted Treatment (MAT) as needed/desired to reduce opioid dependency in the practice's patient population. Practices that seek waiver must be both willing and able to deliver Medication Assisted Treatment to their patients.

PCP and Specialist Guidelines:

a. For more information on Medication Assisted Treatment, refer to the following websites: https://www.samhsa.gov/medication-assisted-treatment and https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm600092.htm

• Walk through a planned preventive visit - what info is provided to the patient prior to the visit, what occurs during and post visit.

10.0 Linkage to Community Services

Goal: Expand the PCMH-Neighborhood to include community resources. Incorporate use of community resources into patients' care plans and assist patients in accessing community services.

8 total capabilities; 1 required
All capabilities applicable to: Adult and Peds patients

Applicable to PCPs and specialists.
When patient is co-managed by PCP and specialist, roles must be clearly defined regarding who is responsible for ensuring patients receive needed community services.

10.1
PO has conducted a comprehensive review of community resources for the geographic population that they serve, in conjunction with Practice Units

PCP and Specialist Guidelines:

a. The review may take place within the context of a multi-PO effort
b. Review should include health care, social, pharmaceutical, mental health, and rare disease support associations
    i. If comprehensive community resource database has already been developed (e.g., by hospital, United Way) then further review by PO is not necessary
    ii. Review may include survey of practice units to assist in identifying local community resources

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Discuss review process with PO representation at the visit. • United Way or other formal databases will count	

10.2 - Required
PO maintains a community resource database based on input from Practice Units that serves as a central repository of information for all Practice Units.

PCP and Specialist Guidelines:

a. The database may include resources such as the United Way's 2-1-1 hotline, and links to online resources such as www.auntbertha.com.
b. At least one staff person in the PO is responsible for conducting a semiannual update of the database and verifying local resource listings (PO may coordinate with Practice Unit staff to ensure resource reliability)

i. During the update process, consideration may be given to including new, innovative community resources such as Southeast Michigan Beacon Community's Text4Health program
ii. It is acceptable for staff to not verify aggregate listings (such as 2-1-1) if they are able to document how often the listings are updated by the resource administrator

c. Resource databases are shared with other POs, particularly in overlapping geographic regions
d. Portion of database includes self-management training programs available in the community

Required for PCMH Designation: YES	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo examples in the database	

10.3

PO in conjunction with Practice Units has established collaborative relationships with appropriate community-based agencies and organizations

PCP and Specialist Guidelines:

a. Practice or PO in collaboration with practice is able to provide a list of organizations providing services relevant to their patient population in which collaborative, ongoing relationships are directly established
    i. PO in conjunction with practice has conducted outreach to organizations and held in-person meetings or face-to-face events, at least annually, that facilitate interaction between practices and agencies where they discuss the needs of their patient population
b. Collaborative relationships must be established with selected agencies with relevance to patients' needs
c. Collaborative relationships need to be established directly with the individual agencies (not via 2-1-1) and involve ongoing substantive dialogue

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Example of relationship • PO in conjunction w/ PU has conducted outreach to organizations	

10.4

All members of practice unit care team involved in establishing care treatment plans have received training on community resources and on how to identify and refer patients appropriately

PCP and Specialist Guidelines:

a. Training may occur in collaboration with community agencies that serve as subject-matter experts on local resources
b. Training occurs at time of hire for new staff, and is repeated at least annually for all staff

c. Practice unit care team is trained to empower and encourage support staff to alert them to patient's possible psychosocial or other needs
d. PO or Practice Unit administrator assesses the competency of Practice Unit staff involved in the resource referral process at least annually. This may occur in conjunction with community agencies.
    i. For example, practice unit staff are able to explain process for identifying and referring (or flagging for the clinical decision-maker) patients to relevant community resources
    ii. Practice Unit is able to demonstrate that training occurs as part of new staff orientation

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• What training did you receive in developing a process for partnering in community resources for patients? • How did this training improve your process for connecting patients with community resources?	

10.5

Systematic team approach is in place for assessing and educating all patients about availability of community resources and assessing and discussing the need for referral

PCP and Specialist Guidelines:

a. Systematic process is in place for the practice unit team to educate new patients and all patients during annual exam (or other visits, as appropriate) about availability of community resources, and assessing and discussing the need for referral
    i. Assessment and education process must include intake form or screening tool related to social determinants of health, followed up with conversation in which patients are asked whether they or their family members are aware of or in need of community services
    ii. Practice support staff are empowered to alert practice unit staff to possible psychosocial and other needs
    iii. For example, Practice Units may develop an algorithm (or series of algorithms) to guide the assessment and referral process
    iv. Additional information about available community resources should be disseminated via language added to patient-provider partnership documents, PO or Practice Unit website, brochures, waiting room signage, county resource booklets at check-out desk, or other similar mechanisms

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Practice to show tools used for educating patients on community resources • How are a patient's need for resources assessed? What screening tools are utilized?	

10.6
Systematic approach is in place for referring patients to community resources

PCP and Specialist Guidelines:

a. Practice Unit must be able to verbally describe or provide written evidence of systematic process for referring patients to community resources.
    i. For example, systematic process may consist of standardized patient referral materials such as a "prescription form", computer-generated printout that details appropriate sources of community-based care, or other documented process or tools.
    ii. Assessments that identify a patient with need for referral are documented in the medical record to enable providers to follow-up during subsequent visits
    iii. Patients should have access to national and local resources that are appropriate for their ethnicity, gender orientation, ability status, age, and religious preference, including resources that are available in other languages such as Spanish, Arabic, and American Sign Language.
    iv. For example, if Practice Units within a PO have a great deal of diversity within their patient population, the PO may amass specific information about services for those diverse patient groups. Practice Units may also share information about resources for diverse groups.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• What does the referral process look like and who is involved? • Are appointments made for patients? (Dedicated staff member)	

10.7
Systematic approach is in place for tracking referrals of high-risk patients to community resources made by the care team, and making every effort to ensure that patients complete the referral activity

PCP Guidelines:

a. Practice units have the responsibility to identify those patients who are at high risk of complications/decompensation for whom referral to a particular agency is critical to reaching established health and treatment goals.
b. Referrals to community resources should be tracked for high-risk patients. Practice Units are encouraged to create a hierarchy to ensure that vital services (such as referrals to mental health providers) are being tracked appropriately.
c. The purpose of tracking the referrals is to ensure that these high-risk patients receive the services they need.

Specialist Guidelines:

a. Practice units have the responsibility to identify those patients who are at high risk of complications/decompensation for whom referral to a particular agency is critical to reaching established health and treatment goals.

b. Referrals to community resources should be tracked for high-risk patients. Practice Units are encouraged to create a hierarchy to ensure that vital services (such as referrals to mental health providers) are being tracked appropriately.
c. Specialists must ensure that PCPs are notified about referrals to community resources for high-risk patients.
d. The purpose of tracking the referrals is to ensure that these high-risk patients receive the services they need.

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo how follow-up occurs with high-risk patients. What are examples of "high-risk" regarding community resources for the practice?	

10.8

Systematic approach is in place for conducting follow-up with high-risk patients regarding any indicated next steps as an outcome of their referral to a community-based program or agency.

PCP and Specialist Guidelines:

a. Patients may be held partially responsible for the tracking process. For example, Practice Units may use technology such as Interactive Voice Response (IVR) for patients to report initial contact and completion, develop a "passport" that patients can have stamped when they complete trainings or attend a support group, or use existing disease registries such as WellCentive to track community-based referral activities.
b. Process includes mechanism to track patients who decline care and obtain information about reasons care was not sought.

Required for PCMH Designation: NO	Predicate Logic: 10.7
PCMH Validation Notes for Site Visits	
• Systematic process for follow up w/high risk patients regarding next steps	

11.0 Self-Management Support

Goal: Systematic approach to empowering patients to understand their central role in effectively managing their illness, making informed decisions about care, and engaging in healthy behaviors.

8 total capabilities
All capabilities applicable to: Adult and Peds patients

Applicable to PCPs and specialists. When patient is co-managed by PCP and specialist, roles must be clearly defined regarding which provider is responsible for leading self-management support activities and which provider is responsible for reinforcing self-management support activities.

To receive credit for a self-management support capability, basic self-management support delivered in the context of office visits must be available to all patients. Advanced self-management support, delivered by trained care managers in the context of provider-delivered care management services, is expected to be available only to those members who have the provider-delivered care management benefit.

11.1

Clinician who is member of care team or PO staff person is educated about and familiar with self-management support concepts and techniques and works with appropriate staff members at the practice unit at regular intervals to ensure they are educated in and able to actively use self-management support concepts and techniques.

PCP and Specialist Guidelines:

a. The expectation of this capability is that POs are actively empowering the staff within the practice unit to incorporate self-management support efforts into routine clinic process.
b. Regular intervals are defined as a minimum of once per year
    i. New staff must be trained at time of entry to practice
c. Self-management support uses a team-based, systematic, model-driven (including behavioral and clinical dimensions) approach to actively motivating and engaging the patient in effective self-care for identified chronic conditions; must extend beyond usual care such as encouragement to follow instructions
d. Level, type, and intensity of training, education, and expertise may vary, depending upon team members' roles and responsibilities in the Practice Unit
    i. Education must be substantive and in-depth and focus on a particular model of self-management support and not consist of only a brief introduction to the concept. Recommended sites for more information include:
        - IHI Partnering in Self-Management Support: A Toolkit for Clinicians
            - http://www.ihi.org/knowledge/Pages/Tools/SelfManagementToolkitforClinicians.aspx
        - Self-Management Support Information for Patients and Families: http://www.ihi.org/resources/Pages/Tools/SelfManagementToolkitforPatientsFamilies.aspx
        - Flinders Self-Management Model: http://www.flinders.edu.au/medicine/fms/sites/FHBHRU/documents/publications/FLINDERS%20PROGRAM%20INFORMATION%20PAPER%20FINAL_M.pdf
        - South West Self-Management Program: http://www.swselfmanagement.ca/smtoolkit/
        - Motivational Interviewing
            - http://www.motivationalinterviewing.org/
e. Education of practice unit staff members may be provided by PO staff person if the PO staff person has adequate time to provide comprehensive, meaningful education; otherwise, practice unit is responsible for identifying a member of the practice's clinical care team to receive education in self-management support concepts and techniques
f. Appropriate team members should have awareness of self-management concepts and techniques, including:
    i. Motivational interviewing
    ii. Health literacy/identification of health literacy barriers

iii. Use of teach-back techniques
iv. Identification of medical obstacles to self-management
v. Establishing problem-solving strategies to overcome barriers of immediate concern to patients
vi. Systematic follow-up with patients

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Must be in place before 11.2-11.7 • No formal training needed (train the trainer okay), i.e. PTI training, self-management toolkit. • Regular, ongoing staff education regarding self-management techniques. Motivational interviewing, health literacy, teach backs, identification of obstacles • Describe how training has supported interactions with patients in coaching them toward self-efficacy (Minimum 1x/yr. and new staff trained at time of entry into practice).	

11.2

Structured self-management support is systematically offered to all patients in the patient population selected for initial focus (based on need, suitability, and patient interest)

PCP and Specialist Guidelines:

a. Self-management support is assisting patients in implementing their action plan through face-to-face interactions and/or phone outreach in between visits.
b. Self-management support services may be provided in the context of a planned visit
c. An action plan is a patient-specific goal statement that incorporates treatment goals including aspects of treatment that involve self-management. It is not an action step; it is a goal statement.
d. Physicians may provide self-management support within the context of E&M services
    i. At least one other trained member of the care team must be designated as a self-management support resource, with time allocated to work with patients

Required for PCMH Designation: NO	Predicate Logic: 11.1
PCMH Validation Notes for Site Visits	
• Which chronic condition has been chosen as a focus for self-management? • How are patients engaged in self-management? • What tools are used?	

11.3

Systematic follow-up occurs for all patients in the patient population selected for initial focus who are engaged in self-management support to discuss action plans and goals, and provide supportive reminders

PCP and Specialist Guidelines:

a. Follow-up may occur via phone, email, patient portal, or in person, and must occur at least monthly.

Required for PCMH Designation: NO	Predicate Logic: 11.1
PCMH Validation Notes for Site Visits	
• How do you follow up with those patients engaged in self-management and how do you track those patients? • Provide examples of phone outreach between visits? Documentation in the EMR?	

11.4

Regular patient experience/satisfaction surveys are conducted for patients engaged in self-management support, to identify areas for improvement in the self-management support efforts

PCP and Specialist Guidelines:

a. Surveys may be administered electronically, via phone, mail, or in person
b. Results must be quantified, aggregated, and tracked over time
c. Self-management support survey questions may be added to regular patient satisfaction surveys providing sampling is structured to ensure adequate responses from those who actually received self-management support services
d. If survey results identify areas for improvement, timely follow-up occurs (e.g., self-management support efforts are systematized to assure they are available on a timely basis to all patients for whom they are appropriate)

Required for PCMH Designation: NO	Predicate Logic: 11.1, 11.2
PCMH Validation Notes for Site Visits	
• Documented survey results • Demonstrate examples of areas of improvement and action taken based on survey results • Have results improved based on actions taken?	

11.5

Self-management support is offered to multiple populations of patients within the practice's patient population (based on need, suitability and patient interest)

Required for PCMH Designation: NO	Predicate Logic: 11.1, 11.2
PCMH Validation Notes for Site Visits	
• How do you engage patients in self-mgmt? • What tools are you using? • What chronic condition/s have you chosen for self-management?	

11.6

Systematic follow-up occurs for multiple populations of patients within the practice's patient population who are engaged in self-management support to discuss action plans and goals, and provide supportive reminders

PCP and Specialist Guidelines:

a. Follow-up may occur via phone, email, patient portal, or in person, and must occur at least monthly.

Required for PCMH Designation: NO	**Predicate Logic: 11.1, 11.3**
PCMH Validation Notes for Site Visits	
• How do you follow up with those patients engaged in self-management and how do you track those patients? • Provide examples of phone outreach between visits • Documentation in the EHR?	

11.7

Support and guidance in establishing and working towards a self-management goal is offered to every patient, including well patients (e.g., asking well patients about health goals)

PCP and Specialist Guidelines:

a. Self-management goal is developed collaboratively with the patient and is specific and reflective of the patient's interests and motivation

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• How do you engage patients in self-management? • What tools are you using? • How do you follow up with patients engaged in self-management and how do you track those patients? • Provide examples of phone outreach between visits • Documentation in the EHR?	

11.8

At least one member of PO or practice unit is formally trained through completion of a nationally or internationally-accredited program in self-management support concepts and techniques, and regularly works with appropriate staff members at the practice unit to educate them so they are able to actively use self-management support concepts and techniques.

PCP and Specialist Guidelines:

a. Training for self-management techniques should include:
    i. Motivational interviewing
    ii. Health literacy/identification of health literacy barriers
    iii. Use of teach-back techniques

iv. Identification of medical obstacles to self-management
v. Establishment of problem-solving strategies to overcome barriers of immediate concern to patients
vi. Systematic follow-up with patients

b. Practices should seek structured information/approaches/processes, which can be from any legitimate source
c. Self-management training of the practice unit staff must be provided directly by the individual(s) certified as completing the formal self-management training
    i. A "train the trainer" model, where, for example, a PO staff person who has completed a formal self-management training program subsequently trains practice consultants, who in turn train practice unit staff, does not meet the requirements for this capability.
    ii. Examples of training programs that meet the criteria are available from the PGIP Care Management Resource Center at http://micmrc.org/system/files/micmrc-approved-self-management-support-mcm-program-summary-v12a.pdf
    iii. Such programs must be sufficiently robust that they provide ample opportunities for learners to practice new self-management support skills with individualized feedback as part of the practice experience.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Describe how the training has supported interactions with patients in coaching them toward self-efficacy? • Example: Stanford Certified Self-Management Team member	

12.0 Patient Web Portal

Goal: Patients have access to a web portal enabling patients to access medical information and to have electronic communication with providers

14 total capabilities; 3 retired.
All capabilities applicable to: Adult and Peds patients

Applicable to PCPs and specialists.
Patient web portal is a system that supports two-way, secure, compliant communication between the practice and the patient. For capabilities pertaining to patient's use of portal, practice unit staff must be trained in and have implemented this capability, patients must be able to use it currently, and patients must be actively using the portal.

12.1
Available vendor options for purchasing and implementing a patient web portal system have been evaluated

RETIRED

PCP and Specialist Guidelines:

a. Assessment of vendor options may be conducted by PO or Practice Unit.

a. Option should be available to patients, recognizing that not all patients will choose to use these tools

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo of graphing results and how this info is used at point of care	

12.12

Patients actively view visit summaries online that contain patient personal health information that has been reviewed and released by the provider and/or practice

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo of how the patient accesses the medical record & what info is available to them • Elements must include, at a minimum: active diagnoses, current medications, allergies, treatment plan, next steps/follow-up	

12.13

Patients actively schedule appointments electronically through an interactive calendar

PCP and Specialist Guidelines:

a. Patients should have the ability to see currently available appointments and insert themselves into the schedule of the practice. Time slot is then reserved for patient.
    1. May be subject to final confirmation by practice

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo appointment scheduling, ask how PU is notified of scheduled appt. • Cannot be a request only - patients should have the ability to see currently available appointments and insert themselves in to the schedule of the practice. • Time slot is then reserved for patient	

12.14

Practice routinely uses patient portal to prepare patient for planned visits, alerting patients to needed tests that can be done in advance, gathering information about questions and issues patients would like to discuss

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Provide examples of alerts or questionnaire	

13.0 Coordination of Care

Goal: Patient transitions are well-managed and patient care is coordinated across health care settings through a process of active communication and collaboration among providers, patients and their caregivers

12 total capabilities
All capabilities applicable to: Adult and Pediatric patients

Applicable to PCPs. When patient is co-managed by PCP and specialist, roles must be clearly defined regarding which provider is responsible for leading care coordination activities. Applicable to specialists for patients for whom the specialist has lead care management responsibility or when the admission is relevant to the condition being managed by specialist.

13.1

For patient population selected for initial focus, mechanism is established for being notified of each patient admit and discharge or other type of encounter, at facilities with which the physician has admitting privileges or other ongoing relationships

PCP and Specialist Guidelines:

a. Standards for information exchange have been established among participating organizations to enable timely follow-up with patients.
b. Facilities must include hospitals, and may include long-term care facilities, home health care, and other ancillary providers.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Notification of admit/discharge or other health encounter for one chronic condition. Is practice getting info from other locations? • How are patients followed in the hospital? If hospitalists see the PCP's patients, how is info exchanged and notification received of admits and discharges? • If electronic, demo notification of need for info and how the info is sent	

13.2

Process is in place for exchanging necessary medical records and discussing continued care arrangements with other providers, including facilities, for patient population selected for initial focus

PCP Guidelines:

a. Patients are encouraged to request that their practice unit be notified of any encounter they may have with other health care facilities and providers (for example, SNFs, rehab facilities, non-primary hospitals)
b. Practice units are responsible for ensuring that other providers have relevant medical information in a timely manner necessary to make care decisions

Specialist Guidelines:

a. Specialists systematically request that patients provide name of PCP

b. Patients are encouraged to request that their PCP be notified of any encounter they may have with other health care facilities and providers (for example, SNFs, rehab facilities, non-primary hospitals)
c. Practice units are responsible for ensuring that other providers have relevant medical information in a timely manner necessary to make care decisions

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Info exchange process - transfer of care to other providers/facilities. PCP giving info to other locations.	

13.3

Approach is in place to systematically track patient population selected for initial focus.

PCP and Specialist Guidelines:

a. The following information must be tracked for all patients in health care facilities
    i. Facility name
    ii. Admit date
    iii. Origin of admit (ED, referring physician, etc.)
    iv. Attending physician (if someone other than PCP)
    v. Discharge date
    vi. Diagnostic findings
    vii. Pending tests
    viii. Treatment plans
    ix. Complications at discharge

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Assess tracking system for patients in acute, intermediate and home care. • Demonstrate examples of patients being tracked	

13.4

Process is in place to systematically flag for immediate attention any patient issue that indicates a potentially time-sensitive health issue for patient population selected for initial focus

PCP and Specialist Guidelines:

a. For example, home monitoring of CHF patient indicates weight gain, or diabetes patient is treated for cellulitis in ER, or a CHF patient has a change in mental health status

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Provide examples of high-risk triage patient situations (i.e. patient calls w/high glucose, weight gain)	

13.5

Process is in place to ensure that written transition plans are developed, in collaboration with patient and caregivers, where appropriate, for patients in patient population selected for initial focus who are leaving the practice (i.e., because they are moving, going into a long-term care facility, or choosing to leave the practice).

PCP and Specialist Guidelines:

a. Caregivers may include nurse, social workers, or other individuals involved in the patient's care
b. Practice units are responsible for ensuring that written transition plan is provided in a timely manner so that patient can receive needed care
c. Transition plan must consist of either a written summary or clear, concise excerpts from the medical record containing diagnoses, procedures, current medications, and other information relevant during the transition period (e.g., upcoming needed services, prescription refills)
d. A copy of the transition plan must be provided to the patient
e. Inability to develop collaborative plan due to voluntary, precipitous departure of patient from the practice, or unwillingness of the patient to participate, would not constitute failure to meet the requirements of 13.5

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Written transition plans for patients leaving practice • Discuss the process from the time the office is notified that a patient will be leaving the practice. Ask to provide example of a transition plan	

13.6

Process is in place to coordinate care with payer case manager for patients with complex or catastrophic conditions

PCP and Specialist Guidelines:

a. Process may be directed by PO or practice unit
b. Process should include ability to respond to and coordinate with payor case managers when the patient is enrolled in formal case management program
c. Process should include ability to contact health plan case managers when, in the clinician's judgment, unusual circumstances may warrant the coverage of non-covered services, particularly to avoid inpatient admissions or use of other higher-cost services

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Process for case management coordination: BCN is 800-775-2283, BCBSM is 800-845-5982, Blue Cross Complete is 800-228-8554 • Discuss process for referrals to case managers	

13.7

Practice has written procedures and/or guidelines on care coordination processes, and appropriate members of care team are trained on care coordination processes and have clearly defined roles within that process

PCP and Specialist Guidelines:

a. Written procedures and/or guidelines are developed for each phase of the care coordination process
b. The procedures or guidelines are developed by either the PO or practice unit
c. Training/education of members of care team are conducted by either the PO or practice
d. Training occurs at time of hire for new staff, and is repeated at least annually for all staff

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Written procedure or guideline for care coordination process with clearly defined roles (i.e. home care, rehab, acute hospital, SNF)	

13.8

Care coordination capabilities as defined in 13.1-13.7 are in place and extended to multiple patient populations that need care coordination assistance

PCP Guidelines:

a. Applicable to all patients with chronic conditions
b. Written procedures and/or guidelines on care coordination processes may be developed by the PO or practice

Specialist Guidelines:

a. Applicable to multiple patient populations relevant to the practice
b. Written procedures and/or guidelines on care coordination processes may be developed by the PO or practice

Required for PCMH Designation: NO	**Predicate Logic: 13.1-13.7**
PCMH Validation Notes for Site Visits	
• Must have 13.1-13.7 in place before 13.8	

13.9

Coordination capabilities as defined in 13.1-13.7 are in place and extended to all patients that need care coordination assistance

PCP and Specialist Guidelines:

a. Written procedures and/or guidelines on care coordination processes may be developed by the PO or practice

Required for PCMH Designation: NO	**Predicate Logic: 13.1-13.8**
PCMH Validation Notes for Site Visits	
• Must have 13.1-13.7 in place before 13.9	

13.10

Following hospital discharge, a tracking method is in place to apply the practice's defined hospital discharge follow-up criteria, and those patients who are eligible receive individualized transition of care phone call or face-to-face visit within 24-48 hours

PCP and Specialist Guidelines:

a. PCP and specialists should coordinate to determine which physician(s) is/are most appropriate for follow-up
b. Hospital discharge follow-up criteria is defined by the practice

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Documentation required for tracking process • PCP and specialists should coordinate to determine which physician(s) is/are most appropriate for follow-up • Who at the PU contacts the patient for the Transition of Care (TOC) visit? • What is the time frame for patient contact (e.g. 24-48 hours?) • Are same day appointments held for TOC visits?	

13.11

Practice is actively participating in the Michigan Admission, Discharge, Transfer (ADT) Initiative

PCP and Specialist Guidelines:

a. Practice maintains an all-patient list that has been sent to MiHIN's Active Care Relationship (ACRS) File in accordance with all MiHIN's specifications
b. The practice maintains an active and compliant status with the statewide health information exchange (HIE) system.
c. The practice has a process for managing protected health information in compliance with applicable standards for privacy and security.
d. The practice connects information received through the HIE process with clinical processes, such as transition of care management following hospitalization.

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Practice maintains an all-patient list that has been sent to MiHIN's Active Care Relationship (ACRS) File in accordance with all MiHIN's specifications • The practice maintains an active and compliant status with the statewide HIE system. • The practice has a process for managing protected health information in compliance with applicable standards for privacy and security. • The practice connects information received through the HIE process with clinical processes, such as transition of care management following hospitalization.	

- Who at the PU has access to the ADT information and how is the information used?
- How often do you access the ADT?
- What is your patient outreach process after an ED visit or IP visit (include timeframe)?

13.12

Practice is actively participating in the Michigan Admission, Discharge, Transfer (ADT) Medication Reconciliation Use Case

PCP and Specialist Guidelines:

a. The practice connects medication reconciliation information received through the HIE process with clinical processes, such as transition of care management following hospitalization, and a process exists for updating patient medical records

Required for PCMH Designation: NO	Predicate Logic: n/a

14.0 Specialist Pre-Consultation and Referral Process

Goal: Process of referring patients from PCPs to specialists, and from specialists to sub-specialists, is well coordinated and patient-centered, and all providers have timely access to information needed to provide optimal care

11 total capabilities; 3 retired
All capabilities applicable to: Adult and Peds patients

Applicable to PCPs and specialists.

14.1

Documented procedures are in place to guide each phase of the specialist referral process – including desired timeframes for appointment and information exchange - for preferred or high-volume providers

PCP Guidelines:

a. Practice unit has defined parameters for specialist referral process, including timeframes, scheduling process, transfer of patient information to specialist, and reporting of results from specialist(s), for preferred and high-volume providers
    i. Parameters include procedures to ensure that specialists are being given the information they need prior to appointments, including but not limited to:
        - Care manager name (if one assigned)
        - Names of other specialists seen for same condition
        - Requested service (e.g., single consult, co-management, assumption of care)
            - Please reference introduction, p. 7

Specialist Guidelines: