BCBSM
Physician Group Incentive Program

Patient-Centered Medical Home Domains of Function

Interpretive Guidelines

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Blue Cross Blue Shield of Michigan
Physician Group Incentive Program

Patient-Centered Medical Home Domains of Function Interpretive Guidelines

Under Blue Cross Blue Shield of Michigan's (BCBSM) Physician Group Incentive Program (PGIP), Patient-Centered Medical Home (PCMH)-based infrastructure and care processes have been organized into 12 "Domains of Function" (listed in Table of Contents). Each PCMH Domain of Function has a set of required capabilities, collaboratively developed by BCBSM and PGIP Physician Organizations (POs). To provide further information regarding the definition of each required capability, a BCBSM-PO team was assembled to review and finalize these PCMH Interpretive Guidelines.

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

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.

Note: Domains 7 and 8 are not included in this document. Domain 7 was previously used to collect evidence-based care data, and Domain 8 is used to collect self-reported electronic prescribing data.

1.0 Patient-Provider Partnership

1.1
Practice unit has developed PCMH-related patient communication tools, has trained staff, and is prepared to implement patient-provider partnership with each established patient, which may consist of a signed agreement or other documented patient communication process to establish patient-provider partnership

Guidelines:

- Patient communication process must include a conversation between the patient and a member of the clinical practice unit team. In extenuating

circumstances, well-trained Medical Assistants who are highly engaged with patient care may be considered a member of the clinical practice unit team.

- The patient-provider partnership must only be established one time per patient.
- Documentation may consist of note in medical record, sticker placed on front of the chart, indicator in patient registry, patient log, or similar system that can be used to identify the percent of patients with whom the partnership has been discussed.
- Documents and patient education tools are developed that explain PCMH concepts and outline patient and provider roles and responsibilities.
- Practice unit team members and all appropriate staff are educated/trained on patient-provider partnership concepts and patient communication processes
- Process has been established for patients to receive PCMH information, and for practitioner to have conversation with patients about PCMH patient-provider partnership.
- Mechanism and process has been developed to document establishment of patient-provider partnership in medical record or patient registry.

1.2
Process of reaching out to established patients is underway, and practice unit is using a systematic approach to inform patients about PCMH, including patients who do not visit the practice regularly

Guidelines:

- Established patients are defined as, at a minimum, all patients within the practice (regardless of insurance coverage) who were seen within the past 12 months.
- Examples of outreach include discussion at the time of visit, mailings, emails, websites, telephone outreach, or other electronic means,
  - Mass mailings do not meet the requirements for 1.3 through 1.8
  - Outreach materials should explain the PCMH concept and patient-provider partnership
  - For any reference to a practice having “BCBSM Designation status” please reference BCBSM’s recommended language for communications to patients from PCMH-Designated practices
- For those patients who do *not* come into the practice regularly, outreach must consist of distribution of material that the patient receives personally, either via mail, email, telephone, or patient portal.

1.3
Patient-provider agreement or other documented patient communication process is implemented and documented for at least 10% of current patients

Guidelines:

- “Current” patients are defined as patients who the practice unit considers to be active in the practice (e.g., practices may define “current” as seen within the past 12 months or 24 months)

- Establishment of patient-provider partnership *must* include conversation between patient and a member of the practice unit clinical team
  - In extenuating circumstances, well-trained Medical Assistants who are highly engaged with patient care may be considered a member of the clinical practice unit team.
  - Conversation should preferably take place in person, but may take place over phone in extenuating circumstances, for a limited number of patients
  - Other team members may begin the conversation, or follow-up after physician conversation with more detailed discussion/information, but a clinical team member must participate in at least part of the patient-provider partnership conversation
- Conversation may be documented in medical record, patient registry, or other type of list.
- Practice ***must*** also have mechanism to track percent of patients that have established partnership, and ***be able to provide data*** during site visit showing denominator (total number of "current" patients in the practice) and numerator (total number of patients in the denominator with whom conversations have been held and partnerships established at any point in the past).

1.4
Patient-provider agreement or other documented patient communication process is implemented and documented for at least 30% of current patients

Guidelines:
- Reference 1.3

1.5
Patient-provider agreement or other documented patient communication process is implemented and documented for at least 50% of current patients

Guidelines:
- Reference 1.3

1.6
Patient-provider agreement or other documented patient communication process is implemented and documented for at least 60% of current patients

Guidelines:
- Reference 1.3

1.7
Patient-provider agreement or other documented patient communication process is implemented and documented for at least 80% of current patients

1.8
Patient-provider agreement or other documented patient communication process is implemented and documented for at least 90% of current patients

Guidelines:
- Reference 1.3

2.0 Patient Registry

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.

Nine 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, and 2.18). The other nine Patient Registry capabilities pertain to registry functionality (2.2, 2.3, 2.4, 2.5, 2.6., 2.7, 2.8, 2.9, and 2.14). 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

Guidelines:
- A patient registry is a database that contains several dimensions of clinical data on patients to enable providers to manage their population of patients. Relevant clinical information that is the focus of attention in established 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 prescription in use, physical findings, and patient behaviors such as peak flow meter use or daily salt intake).
- Registry data must be in the form of data fields that are accessible for tabulation and population management.
- Registry must include all established patients with the disease referenced in the capability, regardless of insurance coverage (including Medicare patients)
- Patients assigned by managed care organizations do not have to be included in registry if they are not established patients (reference 2.15).
- Patient information may be entered by the practice, populated from EMR or other electronic or manual sources, or populated with payer-provided data
    - Registry must include data pertinent to the clinical performance measures contained in the EBCR (e.g., BCBSM-provided data or similar data from other sources)

- Registry may initially be a component of EMR for basic-level functioning, as long as the practice or the PO has the capability to use the EMR to generate routine population-level performance reports and reports on subsets of patients requiring active management.
    - 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
- Reference AAFP article for additional information on creating a registry: http://www.aafp.org/fpm/20060400/47usin.html

2.2
Registry incorporates patient clinical information, for all established patients in the registry, for a substantial majority of health care services received at other sites that are necessary to manage chronic care and preventive services for the population

Guidelines:

- Registry may be paper or electronic
- "All patients in the registry" may consist, for example, of diabetes patients only, if practice unit has only implemented task 2.1.
- 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
- Other sites and service types are defined as labs, inpatient admissions, ER, UCC, and pharmaceuticals (with dates and diagnoses where applicable).
- The definition of "substantial majority of health care services" is three-quarters of preventive and chronic condition management services rendered to patients.
- 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

2.3
Registry incorporates evidence-based care guidelines

Guidelines:

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

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

Guidelines:

- Registry functionality may be paper or electronic.
- Practice unit has and is fully using the capability to generate up-to-date, integrated individual patient reports at the point and time of care to be used during the visit.
- EMR would meet the requirements of this capability provided it has evidence-based guidelines embedded in the tool, 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.

2.5
Registry contains information on the individual attributed practitioner for every patient currently in the registry who has a medical home in the practice unit

Guidelines:

- Registry may be paper or electronic
- The individual practitioner responsible for the care of each patient is identified in the registry
    - Occasional gaps in information about some patients' individual attributed practitioner due to changes in medical personnel are acceptable

2.6
Registry is being used to generate routine, systematic communication to patients regarding gaps in care

Guidelines:

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

2.7
Registry is being used to flag gaps in care for every patient currently in the registry

Guidelines:

- Registry may be paper or electronic.
- Registry must have capability to identify all patients with gaps in care based on evidence-based guidelines incorporated in the registry.

- EMR 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.

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

Guidelines:

- Registry may be paper or electronic.
- Registry must contain all relevant patient demographics, such as name, gender, age.

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

Guidelines:

- Practice unit must have capability 2.2 in place in order to receive credit for 2.9
- All entities must flow electronically into the registry
- Data is housed electronically
- 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 share responsibility for health care.
- 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.

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

Guidelines:

- Reference 2.1.

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

Guidelines:

- Reference 2.1.

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

Guidelines:

- Reference 2.1.

2.13

Registry is being used to manage patients with at least 2 other chronic conditions 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

Guidelines:

- Examples of other chronic conditions include (but are not limited to) depression or sickle cell anemia
- Reference 2.1.

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

Guidelines:

- Reference 2.1.
- Registry must include all current patients in the practice, including well patients, regardless of insurance coverage and including Medicare patients
- 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).

2.15

Registry incorporates patients who are assigned by managed care plans and are not established patients in the practice

Guidelines:

- Patients assigned by managed care plans who are not established patients must be included in the registry, and active outreach conducted to engage them as established patients

2.16

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

Guidelines:

- Reference 2.1.

2.17

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

Guidelines:

- Reference 2.1.

2.18

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

Guidelines:

- Reference 2.1.

3.0 Performance Reporting

Seven of the Performance Reporting capabilities identify the population(s) of patients included in the reports (3.1, 3.3, 3.6, 3.10, 3.11, 3.12, and 3.13). The other six Performance Reporting capabilities pertain to report attributes (3.2, 3.4, 3.5, 3.7, 3.8, and 3.9). All capabilities pertaining to report attributes that are marked as in place must be in place for each population of patients marked as included in the reports.

3.1

Performance reports that allow tracking and comparison of results at a specific point in time across the population of patients are generated for: Diabetes

Guidelines:

- Performance reports are systematic, routine, aggregate-level reports that provide current, clinically meaningful health care information on the entire population of patients of all ages that are included in the registry (e.g., all diabetics, regardless of payor and including Medicare patients), allowing comparison across the population of patients, at a single point in time.
- The performance reports must be actively analyzed and used in self-assessment of provider performance
- The reports must contain several dimensions of clinical data on patients to enable providers to manage their population of patients. Relevant clinical information that is the focus of attention in established generally accepted guidelines and is incorporated in common quality measures pertinent to the chronic illness must be incorporated in the reports (i.e., physiologic parameters, lab results, medication prescription in use, physical findings, and patient behaviors such as peak flow meter use or daily salt intake)
- It is acceptable for the performance reports to be produced and distributed on a regular basis by the PO or sub-PO, as long as the practice units have the capability to request and receive reports on a timely basis.

3.2
Performance reports are generated at the population level, Practice Unit, and individual provider level

<u>*Guidelines:*</u>

- Population level optimally consists of PO and/or sub-PO population, but alternatively, as the PO works towards implementing registry capabilities across all practice units, the population level report may be based on a meaningful subset of relevant aggregated practice unit performance
- Performance reports provide information and allow comparison at the population, practice unit, and individual provider level for all patients currently in the registry, regardless of insurance coverage and including Medicare patients

3.3
Performance reports include patients with at least 2 other chronic conditions 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

<u>*Guidelines:*</u>

- Reference 2.13
- Performance reports are being generated on the population of patients with at least 2 **other chronic conditions** 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 (regardless of insurance coverage and including Medicare patients).

3.4
Data contained in performance reports has been fully validated and reconciled to ensure accuracy

3.5
Trend reports are generated, enabling physicians and their POs/sub-POs to track, compare and manage performance results for their population of patients over time

<u>*Guidelines:*</u>

- Performance reports include both current and past health care information for the population of patients currently in the registry (regardless of insurance coverage and including Medicare patients), allowing analysis and comparison of results across time (e.g., quarter to quarter, year to year).
- Trend reports must be generated by the PO/sub-PO at the individual provider, practice unit, and population level
- Population level optimally consists of PO and/or sub-PO population, but alternatively, as the PO works towards implementing registry capabilities

across all practice units, the population level report may be based on a meaningful subset of relevant aggregated practice unit performance

3.6
Performance reports are generated for the population of patients with: Pediatric Obesity

Guidelines:

- Reference 3.1.

3.7
Performance reports include all current patients in the practice, including well patients, and include data on preventive services

Guidelines:

- Performance reports include all current patients in the practice, including well patients, as defined in 2.14
- Reports include preventive services information

3.8
Performance reports include patient clinical information for a substantial majority of health care services received at other sites that are necessary to manage chronic care and preventive services for the population

Guidelines:

- Reference guidelines for Capability 2.2
- For all established patients in the registry, the performance reports are expected to include treatment information pertinent to standard quality metrics (e.g., use of beta blockers following AMI) but are not expected to contain comprehensive treatment information as this level of information is often contained in detailed narrative text in clinical notes.
- Reportable items could include diagnosis, and associated labs, physiologic parameters such as blood pressure, medications or diagnostic services provided during the encounter.

3.9
Performance reports include information on services provided by specialists

Guidelines:

- Reference 3.1
- Information on key preventive or disease specific services provided by specialists (e.g., ob-gyn, ophthalmologists, podiatrists, endocrinologists) is incorporated into performance reports.

3.10
Performance reports are generated for the population of patients with: Persistent Asthma

Guidelines:
- Reference 3.1

3.11
Performance reports are generated for the population of patients with: Coronary Artery Disease [not applicable to pediatric practices]

Guidelines:
- Reference 3.1

3.12
Performance reports are generated for the population of patients with: Congestive Heart Failure [not applicable to pediatric practices]

Guidelines:
- Reference 3.1

3.13
Performance reports are generated for the population of patients with: Pediatric ADD/ADHD

Guidelines:
- Reference 3.1

4.0 Individual Care Management

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

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

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 at least one chronic condition

Guidelines:

- The integrated team of multi-disciplinary providers must consist of at least 3 non-physician members, including an RN and at least 2 of the following: 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 (Bachelors 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
    - When they are unable to include RNs or PharmDs on 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.
- Practice unit team members hold regular team meetings and/or other structured communications about patients whose chronic conditions are being actively managed.
- 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 PCMH practice.
    - When care is delivered by travel teams or at sites other than the PCMH practice:
        - the care must be fully coordinated by a PCMH practice team member or a health navigator who has ongoing communication with the practice
        - the PCMH 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 patients to engage the patient in actively addressing ongoing health needs and health care goals on a longitudinal basis
    - The multi-disciplinary providers are not required to be employees of the PCMH 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
    - The care management services must be coordinated and integrated with the patient's overall care plan
        - 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
        - Referrals to hospital-based diabetes educators that take place in the context of an overall coordinated, integrated care plan and include communication between the diabetes educator and physician, as well as ongoing patient outreach and communication, would meet the requirements for capability 4.2

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

Guidelines:

- Guidelines are available and used at the point of care by all clinical staff in the Practice Unit
    - Guidelines are activated and used regularly to provide alerts about gaps in care on the Point of Care report or in the EMR
- 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
    - Guidelines are actively used to monitor, track, and conduct outreach to patients to schedule care as needed
- Guidelines are used by PO to evaluate performance of physicians, Practice Units, and PO.

4.4
PCMH patient satisfaction/office efficiency measures are systematically administered

Guidelines:

- 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
    - 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 single specific chronic condition, providing they are capturing 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

  - Reference information at Institute for Healthcare Improvement: http://www.ihi.org/IHI/Topics/OfficePractices/Access/Measures/
- 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]***

4.5
Development of written action plan and goal-setting is systematically offered to all patients with the chronic condition selected for initial focus, with substantive patient-specific and patient-friendly documentation provided to the patient

Guidelines:
- Physicians and other practice team members are actively involved in working with patients to use goal-setting techniques and develop action plans
  - 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)
- Reference information provided at the Improving Chronic Illness Care website: http://www.improvingchroniccare.org/index.php?p=self-management_support&s=39

4.6
A systematic approach is in place for appointment tracking and generation of reminders for all patients with the chronic condition selected for initial focus

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

4.7
A systematic approach is in place to ensure that follow-up for needed services is provided for all patients with the chronic condition selected for initial focus

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

4.8
Planned visits are offered to all patients with the chronic condition selected for initial focus

Guidelines:

- Planned visits consist of a documented proactive, comprehensive approach to ensure that patients receive needed care in an efficient and effective manner.
  - Planned visits include the well-orchestrated, team-based approach to managing the patient's care during the visit, all 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.
- Reference information provided at the Improving Chronic Illness Care website: http://www.improvingchroniccare.org/index.php?p=Planned_Visits&s=48
- "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 nor productive for the provider and patient.
- Key Components of a Planned Visit
  - 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.
  - Call a Patient In For a Visit
    - Develop a script for the call, and 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.
  - 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.
  - 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'."

4.9
Group visit option is available for all patients in the practice unit with the chronic condition selected for initial focus (as appropriate for the patient)

Guidelines:

- Reference AAFP information on group visits at: http://www.aafp.org/fpm/20060100/37grou.html
- 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.)
- 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.
  - 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.
- The clinician is directly involved and meets with each patient individually
- Members of the care management team may take vital signs and other measurements and assist with individual encounters
- 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."
- Group visits generally last from two to 2.5 hours and include no more than 20 patients at a time.
- Group visits may be conducted in collaboration with other Practice Units

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

Guidelines:

- Chronic conditions under 4.10 are defined as any condition requiring maintenance drug therapy.
- 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.

4.11
Action plan development and goal-setting is systematically offered to all patients with chronic conditions or other complex health care needs prevalent in practice's patient population

Guidelines:
- See guidelines for 4.5

4.12
A systematic approach is in place for appointment tracking and generation of reminders for all patients

Guidelines:
- See guidelines for 4.6

4.13
A systematic approach is in place to ensure follow-up for needed services for all patients

Guidelines:
- See guidelines for 4.7

4.14
Planned visits are offered to all patients with chronic conditions prevalent in practice population

Guidelines:
- See guidelines for 4.8

4.15
Group visit option is available to all patients with chronic conditions prevalent in practice population

Guidelines:
- See guidelines for 4.9

5.0 Extended Access

5.1
Patients have 24-hour access to a clinical decision-maker by phone, and clinical decision-maker has a feedback loop within 24 hours or next business day to the patient's PCMH

Guidelines:

- Clinical decision-maker must be an M.D., D.O., P.A., or N.P. If not M.D. or D.O., clinical-decision maker must have ability to contact supervising M.D. or D.O. on an immediate basis if needed
    - Clinical decision-maker may be, but is not required to be, the patient's primary care provider
- Clinical decision-maker has the ability to direct the patient regarding self-care or to an appropriate level of care.
- Clinical decision-maker communicates all clinically relevant information via phone conversation directly to patient's primary physician, by email, by automated notification in an EMR system, or by faxing directly to primary physician regarding the interaction within 24 hours (or next business day) of the interaction
- Clinical decision-maker responds to patient inquiry in a timely manner (generally 15-30 minutes, and no later than 60 minutes after initial patient inquiry)

5.2
Clinical decision-maker accesses and updates patient's EMR or registry info during the phone call

Guidelines:

- Clinical decision-maker (as defined in 5.1) must routinely have access to and update patient's EMR or registry information during all calls"
    - Occasional technical problems, such as failure of internet service in rural areas, may occur and would not constitute failure to meet the requirements of 5.2 as long as access to the EMR or registry is typically and routinely available

5.3
Provider has made arrangements for patients to have access to non-ED after-hours provider for urgent care needs during at least 8 after-hours per week and, if different from the PCP office, after-hours provider has a feedback loop within 24 hours or next business day to the patient's PCMH

Guidelines:

- After-hours is defined as office visit availability during weekday evening (e.g., 5-8 pm) and/or early morning hours (e.g., 7-9 am) and/or weekend hours (e.g., Saturday 9-12), sufficient to reduce patients' use of ED for non-ED care
- After-hours provider may be at Practice Unit site or may be in a physically separate location (e.g., an urgent care location or a separate physician office) as long as it is within 30 minutes travel time of the PCMH
    - Services provided by the after-hours provider must be billable as an office visit or an urgent care visit, not as an ER visit
- If after-hours provider is different from Practice Unit (e.g., they are an urgent care center or a physician who shares on-call responsibilities), there must be an established arrangement for after-hours coverage, and the after-hours provider must be able to provide feedback regarding care encounter to the patient's Practice Unit within 24 hours or on the next business day
- Practice Units may team with other practice units/physicians to provide after-hours urgent care

5.4
A systematic approach is in place to ensure that all patients are fully informed about after-hours care availability and location, at the PCMH site as well as other after-hours care sites, including urgent care facilities, if applicable

5.5
Practice Unit has made arrangements for patients to have access to non-ED after-hours provider for urgent care needs (as defined under 5.3) during at least 12 after-hours per week

<u>Guidelines:</u>

- See guidelines for 5.3

5.6
Non-ED after-hours provider for urgent care accesses and updates the patient's EMR or patient's registry record during the visit

<u>Guidelines:</u>

- Reference 5.3 for definition of non-ED after-hours provider for urgent care needs
- Clinical decision-maker <u>must</u> routinely have access to and update patient's EMR or registry information during all visits
  - o Occasional technical problems, such as failure of internet service in rural areas, may occur and would not constitute failure to meet the requirements of 5.6 as long as access to the EMR or registry is typically and routinely available

5.7
Advanced access scheduling is in place, reserving at least 30% of appointments for same-day appointments for acute and routine care (i.e., any elective non-acute/urgent need, including physical exams and planned chronic care services, for established patients)

<u>Guidelines:</u>

- 30% of the day's appointments should be available at the start of business for same-day appointments for both acute and routine care needs
  - o In unusual, extenuating circumstances (such as a solo practice in a rural or urban under-served area), practice units may meet the requirements of capability 5.7 by having a routine, systematic procedure that practice unit clinicians remain after-hours as necessary to see the majority of patients requesting routine or acute care
- Written policy for advanced access is available
  - o Patients are aware of policy and do not feel that they must self-screen to avoid imposing on practice unit staff
- Patients can be accommodated throughout the day (not only during lunch or after-hours)
- Patients are seen on a timely basis with no excessive waiting time

- Patients can be seen by PAs/NPs or by any physician in practice
- **If practices does not have an approach to scheduling that closely follows the structure and process of formal open access scheduling consistent with the sources cited herein, then must have documented policy and procedures demonstrating that the practice's advanced access approach has the following attributes referenced at the following sites:**
    - **http://www.aafp.org/fpm/20000900/45same.html.**
    - Reference Institute for Healthcare Improvement articles at http://www.ihi.org/IHI/Topics/OfficePractices/Access/Changes/IH **f**or information on implementing advanced access

5.8
Advanced access scheduling is in place reserving at least 50% of appointments for same-day appointment for acute and routine care (i.e., any elective non-acute/urgent need, including physical exams and planned chronic care services, for established patients)

Guidelines:
- 50% of the day's appointments should be available at the start of the business day for same-day appointments for acute and routine patient needs
- Reference 5.7

5.9
Practice unit has telephonic or other access to interpreter(s) for all languages common to practice's established patients.

6.0 Test Results Tracking & Follow-up

6.1
Practice has test tracking process/procedure documented, which requires tracking and follow-up for all tests and test results, with identified timeframes for notifying patients of results

Guidelines:
- Test tracking procedure must be in writing and identify all steps in process and timeframes

6.2
Systematic approach and identified timeframes are in place for ensuring patients receive needed tests and practice obtains results

Guidelines:
- Follow-up occurs with patients to ensure necessary tests are performed
- Communication process are in place with testing entities as necessary to ensure results are received

- Result are reviewed, signed, and dated by the physician and filed in the patient's medical record

6.3
Process is in place for ensuring patient contact details are kept up to date

Guidelines:

- Patients are asked at every visit to confirm that address and phone numbers are current

6.4
Mechanism is in place for patients to obtain information about normal tests

Guidelines:

- Patients are informed about how to access normal test results
- Process may use any of the following mechanisms:
    - Patient phone call to specific phone number at practice
    - Phone call from practice to patient
    - Mail from practice
    - Patient access via secure web portal (in conjunction with one of the above options for patients without internet access)

6.5
Systematic approach is used to inform patients about abnormal test results

Guidelines:

- Systematic approach is in place to flag as high priority results where follow-up is essential and the risk of not following up is high, i.e., tissue biopsies, diagnostic mammograms, INR tests
- For high priority results, patient is contacted by phone (repeated attempts at different times of day, on different days if necessary; if necessary and acceptable to patient, email or patient portal may be used to request the patient call office; as a last resort, results may be sent by registered mail)
    - For low priority results, such as minor lab abnormalities, contact may be by letter
- Systematic approach is in place to ensure communication process is clear and patients understand implications of test results

6.6
Systematic approach is used to ensure that patients with abnormal results receive the recommended follow-up care within defined timeframes.

Guidelines:

- Patients requiring follow-up are flagged and follow-up timeframes are specified
- Cancellations and no-show appointments are tracked and assessed to determine whether any patients require follow-up
- Outcomes of follow-up action are filed in patient's medical record

6.7
Systematic approach is used to document all test tracking steps in the patient's medical record

Guidelines:

- All phone calls, letters, and other communications with patient regarding testing and test results are documented in the patient's medical record

6.8
All clinicians and appropriate office staff are trained to ensure adherence to the test-tracking procedure; all training is documented either in personnel file or in training logs or records

Guidelines:

- Practice unit or PO maintains record of training and can provide training content for review

6.9
Practice has Computerized Order Entry integrated with automated test tracking system

Guidelines:

- Test-tracking system has Computerized Order Entry system structured to log all test orders and is linked to automated tracking system that supports caregiver follow-up
- Test tracking system has the ability to electronically receive and track results

9.0 Preventive Services

9.1
Primary prevention program is in place that focuses on identifying and educating patients about personal health behaviors to reduce their risk of disease and injury.

Guidelines:

- Primary prevention is defined as inhibiting the development of disease before it occurs. Secondary prevention, also called "screening," refers to measures that detect disease before it is symptomatic. Tertiary prevention efforts focus on people already affected by disease and attempt to reduce resultant disability and restore functionality.
- Patient questionnaire or other mechanism is used to elicit information about personal health behaviors that may be contributing to disease risk
  - During well-visit exam and initial intake for new patients
  - During other visits when behavior may be relevant to acute concern (e.g., tobacco use when patient presents with cough)
- Patient assessment addresses personal health behaviors and disease risk factors, based on age, gender, health issues

- Behaviors and risks assessed should include a majority of the following, as appropriate to the patient population: Alcohol and Drug Use, Breast Self-Examination, Awareness of Lead Exposure, Low Fat Diet and Exercise, Use of Sunscreen, Safe Sex, Testicular Self-Examination, and Tobacco Avoidance

9.2
A systematic approach is in place to providing preventive services

Guidelines:

- Preventive care guidelines are integrated into clinical practice (e.g., Michigan Quality Improvement Consortium - www.mqic.org/guid.htm). Examples of appropriate Guidelines include:
    - Adult Preventive Services Guideline 18-49 Yrs
    - Adult Preventive Services Guideline 50-65 Yrs
    - Childhood Overweight Prevention Guideline
    - Prevention of Unintended Pregnancy in Adults
    - Preventive Service for Children & Adolescents Ages Birth – 24 Months
    - Preventive Service for Children and Adolescents Ages 2-18 Yrs
    - Tobacco Control Guideline

- Systematic appointment tracking system (implemented as part of Individual Care Management Initiative) is in place

9.3
Strategies are in place to promote and conduct outreach regarding ongoing well care visits and screenings for all populations, consistent with guidelines for such age and gender-appropriate services promulgated by credible national organizations

Guidelines:

- Systematic reminder system is in place and incorporates the following elements:
    - Age appropriate health reminders (e.g., annual physicals).
    - Age appropriate immunization information consistent with most current evidence-based guidelines
    - If reminders are generated by PO, offices should have knowledge of the process/
- For children and adolescents from birth to 18 years of age examples of outreach strategies may include birthday reminders for well-visits, kindergarten round-up, flu vaccine reminders, health fairs, brochures, school physical fairs.
- For adults, examples of outreach strategies may include annual health maintenance examination reminders, and age and gender-appropriate reminders about recommended screenings (e.g., mammograms)
- Outreach should be systematic and consistent with evidence-based guidelines

9.4

Practice has process in place to inquire about a patient's outside health encounters and has capability to incorporate information in patient tracking system or medical record

Guidelines:

- "Outside health encounter information" includes services such as immunizations provided at health fairs
- Practice unit should include actual/estimated date of service in the medical record whenever possible
- Information may be included in historical section of record

9.5

Practice has a systematic approach in place to ensure the provision/documentation of tobacco use assessment tools and advice regarding smoking cessation

Guidelines:

- Examples may include yearly assessment sheet, tobacco use intervention programs

9.6

Written standing order protocols are in place allowing Practice Unit care team members to authorize and deliver preventive services according to physician-approved protocol without examination by a clinician

Guidelines:

- Standing orders are specific orders for office personnel that are signed in advance by the physician authorizing the provision of specified services under certain clinical circumstances, and are reviewed/updated on a regular basis
- Examples include vaccinations, fecal occult blood tests and mammogram orders, medication intensification algorithm for patients with lipid disorder or high blood pressure

9.7

Secondary prevention program is in place to identify and treat asymptomatic persons who have already developed risk factors or pre-clinical disease, but in whom the disease itself has not become clinically apparent.

Guidelines:

- System with guideline-based reminders for age-appropriate risk assessment and screening tests is in place.

  - o Practice Unit may choose to implement tools such as checklists attached to the patient chart, tagged notes, computer generated encounter forms and prompting stickers.
- Mechanisms are established to identify asymptomatic at-risk patients and provide appropriate treatment
- Examples include metabolic syndrome, osteoporosis, coronary artery disease, depression, alcoholism, STDs, accelerated regimen for colon and breast cancer screening in high risk patients

9.8
Staff receives regular training and/or communications in health promotion and disease prevention and incorporates preventive-focused practices into ongoing administrative operations

Guidelines:

- Practice unit staff has received training or educational material has been posted or circulated regarding a full range of preventive services and health promotion issues
  - New hires receive appropriate training
  - Educational material is circulated or posted when guidelines change
    - For example, PO or practice unit staff person may be assigned to update clinical personnel on standards and guidelines such as AHRQ newsletter updates, the immunization schedule & standards issued by the Advisory Committee on Immunization Practices, Alliance of Immunization in Michigan, or Centers for Disease Control and Prevention.
    - For example, information may be provided to practice units educating them on appropriate billing and ICD-9 codes in order to ensure accurate reporting for preventive medicine services (including use of the correct ICD-9 code for a physical)
- Staff is trained (as appropriate to patient population) regarding consistently using and entering information into the Michigan Care Improvement Registry (MCIR)

9.9
Planned visits are offered as a means of providing preventive services in the context of structured health maintenance exams for which the practice team and patient are prepared in advance of the date of service

Guidelines:

- Reference 4.8 for requirements of planned visit

10.0 Linkage to 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

Guidelines:

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

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

Guidelines:

- The database may include resources such as the United Way's 2-1-1 hotline, and links to online resources.
- 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)
    - 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
- Resource databases are shared with other POs, particularly in overlapping geographic regions
- Portion of database includes self-management training programs available in the community

10.3
PO in conjunction with Practice Units has established collaborative relationships with appropriate community-based agencies and organizations

Guidelines:

- PO is able to provide a list of organizations in which collaborative relationships are directly established
- Collaborative relationships must be established with selected agencies with relevance to patients' needs
- Collaborative relationships need to be established directly with the individual agencies (not via 2-1-1) and involve ongoing substantive dialogue

10.4
All members of practice unit care team involved in establishing care treatment plans have received training on community resources so that they can identify and refer patients appropriately

Guidelines:

- Training may occur in collaboration with community agencies that serve as subject-matter experts on local resources
- 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.
    - For example, practice unit staff are able to explain process for identifying and referring patients to relevant community resources
    - Practice Unit is able to demonstrate that training occurs as part of new staff orientation

10.5
Systematic approach is in place for educating all patients about community resources and assessing/discussing need for referral

Guidelines:

- Systematic process is in place for educating new patients and all patients during annual exam (or other visits, as appropriate) about community resources and assessing/discussing need for referral
    - For example, Practice Units may develop an algorithm (or series of algorithms) to guide the referral process
    - Information about available community resources may be disseminated via language added to patient-provider partnership documents, PO or Practice Unit website, brochures or county booklets at check-out desk

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

Guidelines:

- Practice Unit must be able to verbally describe or provide written evidence of systematic process for referring patients to community resources.
    - 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.
    - Patients should have access to 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, and resources available both locally and nationally.
    - 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.

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

Guidelines:

- 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.
- 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.
- The purpose of tracking the referrals is to ensure that these high-risk patients receive the services they need.

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.

Guidelines:

- 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.
- Process includes mechanism to track patients who decline care and obtain information about reasons care was not sought.

11.0 Self-Management Support

Self-management support is a systematic approach to empowering the patient with chronic illness to understand their central role in effectively managing their illness, making informed decisions about care, and engaging in healthy behaviors.

11.1

Member of clinical care team or PO 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. The intent of this capability is to actively empower the staff within the practice unit to incorporate self-management support efforts into routine clinic process.

Guidelines:

- 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
- Level, type, and intensity of training, education, and expertise may vary, depending upon team members' roles and responsibilities in the Practice Unit
    - 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
    - California Healthcare Foundation (Bodenheimer) has a list of recommended self-management support training materials at: http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=134065
    - Information is also available at the Institute for Healthcare Improvement website: http://www.ihi.org/ihi/search/searchresults.aspx?searchterm=self-management+support&searchtype=basic&Start+Search.x=0&Start+Search.y=0
    - Self-management tool kit can be referenced at: http://www.selfmanagementtoolkit.ca/
    - The National Society of Health Coaches also has resources available, at http://www.nshcoa.com/

- 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
- Appropriate team members should have awareness of self-management concepts and techniques, including:
    - Motivational interviewing
    - Health literacy / Identification of health literacy barriers
    - Use of teach-back techniques
    - Identification of medical obstacles to self-management
    - Establishment of problem-solving strategies to overcome barriers of immediate concern to patients
    - Systematic follow-up with patients

11.2
Self-management support is offered to all patients with the chronic condition selected for initial focus (based on need, suitability, and patient interest)

Guidelines:

- Self-management support is assisting patients in implementing their action plan through face-to-face interactions and phone outreach inbetween visits.
- Self-management support services may be provided in the context of a planned visit
- 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.
- Physicians may provide self-management support (but would not be eligible to bill T-codes for such services)

11.3
Systematic follow-up occurs for all patients with the chronic condition selected for initial focus who are engaged in self-management support to discuss action plans and goals, and provide supportive reminders

Guidelines:

- Follow-up may occur via phone, email, patient portal, or in person, and must occur on a timely basis appropriate to the patient's needs, either at the time of visits if they are frequent, or inbetween office visits if they are infrequent.

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

Guidelines:

- Surveys may be administered electronically, via phone, mail, or in person
- 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
- 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)

11.5
Self-management support is offered to patients with all chronic conditions prevalent in the practice's patient population (based on need, suitability and patient interest)

11.6
Systematic follow-up occurs for patients with all chronic conditions prevalent in the practice's patient population who are engaged in self-management support to discuss action plans and goals, and provide supportive reminders

Guidelines:

- Follow-up may occur via phone, email, patient portal, or in person, and must occur on a timely basis appropriate to the patient's needs, either at the time of visits if they are frequent, or inbetween office visits if they are infrequent.

11.7
Support and guidance in establishing and working towards a self-management goal is offered to every patient, including well patients

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.

Guidelines:

- Training for self-management techniques should include:
    - Motivational interviewing
    - Health literacy / Identification of health literacy barriers
    - Use of teach-back techniques
    - Identification of medical obstacles to self-management
    - Establishment of problem-solving strategies to overcome barriers of immediate concern to patients
    - Systematic follow-up with patients
- Practices should seek structured information/approaches/processes, which can be from any legitimate source
- Examples of training programs that meet the criteria include the Stanford Chronic Disease Self-Management Program, the MI PATH program, or the Chronic Care Professional staff accreditation program from the Department of Health and Human Services.
    - 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.

12.0 Patient Web Portal

General Guidelines:

- Patient web portal is a system that supports two-way 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, and patients must be able to use it currently

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

<u>*Guidelines:*</u>

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

12.2 PO or Practice Unit has assessed liability and safety issues involved in maintaining a patient web portal at any level and developed policies that allow for a safe and efficient exchange of information

<u>*Guidelines:*</u>

- Safety issues may include prohibiting electronic communication for emergency situations, etc.
- All messages exchanged must be secure and HIPAA compliant.

12.3 Ability for patients to request and schedule appointments electronically is <u>activated and available</u> to all patients

12.4 Ability for patients to log and/or graphs results of self-administered tests (e.g., daily blood glucose levels) is <u>activated and available</u> to all patients

<u>*Guidelines:*</u>

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

12.5 Providers are automatically alerted by system regarding self-reported patient data that indicates a potential health issue

<u>*Guidelines:*</u>

- "Flags" may be set using customized parameters for individuals based on their care needs.

12.6 Ability for patients to participate in E-visits is activated and available to all patients

<u>*Guidelines:*</u>

- POs and/or Practice Units have developed and implemented protocol for responding to patient messages/requests for e-visits in a consistent and timely manner (e.g., a triage system), using structured online tools.

12.7
Providers are using patient portal to send automated care reminders, health education materials, links to community resources, educational websites and self-management materials to patients electronically

12.8
Patient portal system includes capability for patient to create personal health record, and is activated and available to all patients

Guidelines:
- Content of personal health record may be defined by PO/Practice Unit, within context of patient portal system.

12.9
Ability for patients to review test results electronically is activated and available to all patients

12.10
Ability for patients to request prescription renewals electronically is activated and available to all patients

12.11
Ability for patients to graph and analyze results of self-administered tests for self-management support purposes is activated and available to all patients

Guidelines:
- Option should be available to patients, recognizing that not all patients will choose to use these tools

12.12
Ability for patients to have access to view registries and/or electronic medical records online that contain patient personal health information that has been reviewed and released by the provider and/or practice is activated and available to all patients

13.0 Coordination of Care

13.1
For every patient with chronic condition 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 PCMH physician has admitting privileges or other ongoing relationships

Guidelines:

- Standards for information exchange have been established among participating organizations to enable timely follow-up with patients.
- Requirements pertaining to specialists are addressed in Specialist Referral Process initiative.
- Facilities must include hospitals, and may include long-term care facilities, home health care, and other ancillary providers.

13.2
Process is in place for exchanging necessary medical records and discussing continued care arrangements with other providers, including facilities, for all patients with chronic condition selected for initial focus

Guidelines:

- 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)
- Practice units are responsible for ensuring that other providers have relevant medical information in a timely manner necessary to make care decisions

13.3
Approach is in place to systematically track care coordination activities for each patient with chronic condition selected for initial focus.

Guidelines:

- Processes are structured to allow care coordination across other settings of care, and may include:
  - Facility name
  - Admit date
  - Origin of admit (ED, referring physician, etc.)
  - Attending physician (if someone other than PCP)
  - Discharge date
  - Diagnostic findings
  - Pending tests
  - Treatment plans
  - Complications at discharge

13.4
Process is in place to systematically flag for immediate attention any patient issue that indicates a potentially time-sensitive health issue for all patients with chronic condition selected for initial focus

Guidelines:

- 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

13.5
Process is in place to ensure that written transition plans are developed, in collaboration with patient and caregivers, where appropriate, for patients with chronic condition 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).

Guidelines:

- Caregivers may include nurse, social workers, or other individuals involved in the patient's care
- Practice units are responsible for ensuring that written transition plan is provided in a timely manner so that patient can receive needed care
- 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)
- A copy of the transition plan must be provided to the patient
- 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

13.6
Process is in place to coordinate care with payer case manager for patients with complex or catastrophic conditions

Guidelines:

- Process may be directed by PO or practice unit
- Process should include ability to respond to and coordinate with payor case managers when the patient is enrolled in formal case management program
- 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

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

Guidelines:

- Written procedures and/or guidelines are developed for each phase of the care coordination process
- The procedures or guidelines are developed by either the PO or practice unit
- Training/education of members of care team are conducted by either the PO or practice

13.8

Care coordination capabilities as defined in 13.1-13.7 are extended to* <u>all patients with chronic conditions</u> *that need care coordination assistance

Guidelines:

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

13.9

Coordination capabilities as defined in 13.1-13.7 are extended to* <u>all</u> *patients that need care coordination assistance

14.0 Specialist Referral Process

Separate guidelines are provided for PCP offices and Specialist offices.

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:

- 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)
    - Parameters include procedures to ensure that specialists are being given the information they need prior to appointments

Specialist Guidelines:

- Practice unit has defined parameters for referral process from PCPs who refer high volume of patients, including timeframes, scheduling process, transfer of patient information, and reporting of results
    - Parameters include procedures to ensure that PCPs are providing the information needed by specialist prior to appointments

14.2

Documented procedures are in place to guide each phase of the specialist referral process – including desired timeframes for appointment and information exchange – for other key providers

PCP Guidelines:

- Other key providers are defined as those to whom patient is referred to manage an uncommon chronic condition of special importance to the patient's well-being

Specialist Guidelines:

- Other key providers are defined as PCPs who refer patients for management of an uncommon chronic condition of special importance to the patient's well-being

14.3
Directory is maintained listing specialists to whom patients are routinely referred

PCP Guidelines:

- Practice Units have defined and validated the criteria which are most important to them when referring patients to a specialist, and revise or update database of preferred physicians regularly
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Specialist Guidelines:

- Specialists provide PCPs with information needed to maintain directory

14.4
PO or Practice Unit has developed specialist referral materials supportive of process and individual patient needs

PCP Guidelines:

- Referral materials for processing the referral in the PCP office and for receipt by the specialist include the following information:
    - Basic information about the specialist, including name, office location and hours
    - Expectations about the specialist visit: e.g., consultation, test/procedure, transfer of responsibility for patient management
    - Expected duration of specialist involvement, if PCP is able to determine in advance
    - How quickly patient should see the specialist

- Referral materials may be provided to specialist and patient (where appropriate for patient) in writing or via email
    - If referral materials are not appropriate for patient, verbal or other communication mechanism may be used to ensure patient understands timeframe and purpose of referral

Specialist Guidelines:

- Processes are in place to ensure PCP referral materials are used appropriately by the specialist and other team members in the specialist office

14.5
Practice Unit or designee routinely makes specialist appointments on behalf of patients

<u>*PCP Guidelines:*</u>

- Practice Units may coordinate with central scheduling office or specialist office to have appointments made on behalf of patients in timely manner
- Exceptions may be made if patient prefers to make own appointment, but follow-up should then occur to ensure that patient was able to secure appointment in a timely manner

<u>*Specialist Guidelines:*</u>

- Specialist coordinates with PCPs to make appointments for patients when requested to do so by PCP

14.6
Each facet of the interaction between preferred/high volume specialists and the PCPs at the Practice Unit level is automated by using electronically-based tools and processes to avoid duplication of testing and prescribing across multiple care settings

<u>*PCP Guidelines:*</u>

- Practice Units have built processes into existing patient registry, portal system, or EMR, or utilize other tools (e.g. Fusion by CareFX)
- Policies have been developed to ensure safe, HIPAA compliant information exchange for all information related to the specialist referral process

<u>*Specialist Guidelines:*</u>

- Specialist has capability to accept electronically-generated referrals via patient registry, portal system, or EMR, or other tools (e.g. Fusion by CareFX)
- Policies have been developed to ensure safe, HIPAA compliant information exchange for all information related to the specialist referral process

14.7
For all specialist and sub-specialist visits deemed important to the patient's well-being, process is in place to determine whether or not patients completed the specialist referral in a timely manner, reasons they did not seek care if applicable, additional sub-specialist visits that occurred, specialist recommendations, and whether patients received recommended services

<u>*PCP Guidelines:*</u>

- System must be in place to determine whether the patient was seen, to identify what was done or recommended and whether the recommendations, including testing, procedures or follow up visits, occurred.
- The patient's care plan should be updated to reflect the specialist results and recommendations

Specialist Guidelines:

- System is in place to inform PCPs when patients are seen, identify what was done or recommended and whether the recommendations, including testing, procedures or follow up visits, occurred.

14.8
Appropriate Practice Unit staff is trained on all aspects of the specialist referral process

14.9
Practice Unit regularly evaluates patient satisfaction with most commonly used specialists, to ensure physicians are referring patients to specialists that meet their standards for patient-centered care

PCP Guidelines:

- Evaluation of patient satisfaction may consist of conversations between clinician and patient following specialist visit, patient satisfaction survey results from specialist office, or formal survey conducted by the practice
- Evaluation should be conducted at least annually
- If specialists are not meeting standards for patient-centered care, timely follow-up occurs (e.g., PCP may contact specialist's office to discuss concerns; referral patterns may be modified)
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Specialist Guidelines:

- Specialist conducts patient satisfaction survey and provides results to referring PCPs