

2011-2012 PGIP-PCMH DOMAINS OF FUNCTION AND CAPABILITY SUMMARY

1.0 Patient Provider Partnership

1. Ready to implement: PCMH Tools developed
2. Practice is using systematic approach to provide PCMH outreach and education
3. Patient Provider Agreement (PPA) is documented for at least 10% patient population
4. (PPA) is documented for at least 30% patient population
5. (PPA) is documented for at least 50% patient population
6. (PPA) is documented for at least 60% patient population
7. (PPA) is documented for at least 80% patient population
8. (PPA) is documented for at least 90% patient population

2.0 Patient Registry

1. All payer patient registry for diabetes in place
2. Patient registry includes patient clinical info for majority of health care services
3. Registry includes evidence-based care guidelines
4. Registry info is available at the point of care
5. Registry includes info on attributed physician for each patient
6. Registry can generate automated communication regarding gaps in care
7. Registry being used to flag chronic disease gaps
8. Registry includes info on physiological parameters and demographics
9. Registry is fully electronic
10. All payer patient registry for asthma in place
11. All payer patient registry for CAD in place
12. All payer patient registry for CHF in place
13. All payer patient registry for all chronic conditions in place
14. All payer patient registry includes preventative service guidelines and is used to generate flags
15. Registry incorporates patients who are assigned by managed care plans and are not established patients in the practice
16. Registry is being used to manage all patients with chronic kidney disease
17. Registry is being used to manage all patients with Pediatric Obesity.
18. Registry is being used to manage all patients with Pediatric ADHD

3.0 Performance Reporting

1. Key indicators developed and reports generated for diabetes overtime
2. Performance report by indicator generated at PO, practice, and provider levels.
3. Performance report generated for 2 additional chronic conditions which require patient and population mgmt.
4. Data has been fully validated and reconciled to ensure accuracy
5. Summary and trend performance
6. Performance reports generated for Pediatric Obesity.
7. Performance reports generated for well patients & preventative.
8. Performance reports generated for patients who receive the majority of their services from specialty care.
9. Performance reports include info on services by specialists.
10. Performance reports generated for persistent asthma.
11. Performance reports generated for CAD
12. Performance reports generated for CHF
13. Performance reports generated for Pediatric ADHD

4.0 Individual Care Management

1. Staff have been trained and have knowledge of PCMH and the Chronic Care Model
2. Practice have ability to delivery coordinated care managed services with a integrated team of multidisciplinary providers
3. Approach to ensure an established care guidelines are followed by care team members
4. At least one chronic care condition identified for focus; Key clinical data assembled and tracked for this condition
5. Action plan developed and goal setting offered for patients with selective chronic condition
6. Approach for appt tracking reminders for patients for selective chronic care condition
7. Approach in place to ensure follow-up for needed services for patients for selective chronic are condition

8. Plan visits offered to all patients with selective chronic care condition
9. Group visit option available for selective chronic care condition
10. Medication review management provided at every visit for patients with chronic condition
11. Action developed and goal setting offered for all patients with chronic conditions or other complex health needs
12. Approach in place for appt tracking reminders for all patients
13. Approach in place to ensure follow appt for all patients
14. Plan visits offered to all patients with chronic condition
15. Group visit option available for all patients with chronic condition

5.0 Extended Access

1. Patients have 24 hour access to clinical decision maker by phone with 24 hour feedback loop to patients PCMH
2. Capability 5.1 enhanced by given clinical decision maker access to EMR or patient registry
3. Patients have access to non emergency dept after hours urgent care provider during at least 8 after hours per week, including 24 hour feed to PCP
4. Approach to ensure all patients are fully informed to afterhours urgent care availability is in place
5. Patients have access to non emergency dept after hours urgent care provider during at least 12 after hours per week, including 24 hour feed to PCP
6. Capability 5.3 is enhanced by giving urgent care provider access to EMR or patient registry
7. Advanced access scheduling is in place reserving at least 30% of appt for same day appts.
8. Advanced access scheduling is in place reserving at least 50% of appt for same day appts.
9. Telephonic or other access to translators for all languages common to practices is in place

6.0 Test Results Tracking

1. Policy in place requiring tracking and follow-up for all test results, including time frames
2. Approach and timeframes in place for tracking tests until the results have been received
3. Processes in place for ensuring patient contact details are kept up
4. Mechanism in place for patients to obtain information about normal tests
5. Approach in place to inform patients about abnormal test results
6. Approach uses to ensure patients with abnormal results receive follow-up care
7. Approach used to document all test tracking steps in patient's medical record
8. All staff are trained on test tracking steps in patient's medical record
9. Automated test tracking system with computerized order entry in place

7.0 N/A

8.0 E-Prescribing

1. Practice unit has full e-RX functionality with full utilization (for all scripts that can be legally transmitted electronically) by one or more provider champions while actively taking steps to transition the process of care and to train the rest of the practice for full implementation within 12 months
2. Practice has full e-RX functionality in use by all physicians in practice with full utilization
 - i. Full e-RX defined as: (1) Vendor meets Medicare certification standards (2) Vendor contractually guarantees at least 96% uptime (3) For controlled substances, physicians are able to use e-RX system to obtain decision support and complete medication history

9.0 Preventive Services

1. Primary prevention program focused on educating patients about personal health behaviors to reduce their risk of disease and injury
2. A systematic approach in place to providing preventative services
3. Strategies are in place to promote ongoing well care visits and screening for all populations

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4. Process in place to inquire about patients outside health encounters and ability to incorporate info into medical record
5. Systematic approach in place to ensure provision documentation of tobacco use assessment tools and advice regarding smoking cessation
6. Standing order protocol are in place allowing practice care team members to authorize and deliver preventative services according to physician approved protocol w/o doctor exam
7. Secondary prevention program is in place to treat asymptomatic persons who have already developed risk factors or clinical disease, but no official diagnosis.
8. Staff receives regular training in health promotions and disease prevention and incorporates into ongoing operations.
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
7. Providers use patient portals to send automated care reminders, education materials, links to community resources, self mgmt materials to patients electronically
8. Patient portal system includes capability for patient to create personal health record
9. Ability for patients to review test results electronically
10. Ability for patients to request prescription renewals electronically
11. Ability for patients to graph and analyze self-administered test s for self-mgmt support purposes
12. Ability for patients to have access to view registries online that contain patient PHI that has been released by provider

10.0 Linkage to Community Services

1. PO has conducted a comprehensive review of community resources for the geographic population that they serve
2. PO maintains a community resource database on input from practices that serve as a central repository of information for all practices
3. PO w/ practices has established collaborative relationships with appropriate community based agencies and organizations
4. All members of practice unit care team involved in establishing care treatment plans have received training on community resources so that they identify and refer patients appropriately
5. Systematic approach is in place for educating all patients about community resources and assessing need for referrals
6. Systematic approach in place for referring patients to community resources
7. Systematic approach in place for tracking referrals of high-risk patients to community resources
8. Systematic approach in place for conducting follow-up with high risk patients regarding any indicted next steps

11.0 Self-Management Support

1. Practice is educated about and familiar with self-management support concepts and techniques and works w/ staff at practice to ensure educated and able to use techniques
2. Self-management support offered to all patients with the chronic condition selected for initial focus
3. Systematic follow-up occurs for all patients with the chronic condition selected for initial focus who are engaged in self-management support
4. Regular patient satisfaction surveys are conducted for patients engaged in self-management support
5. Self-management support is offered to patients with all chronic conditions
6. Systematic follow-up occurs for patients w/ all chronic conditions who are engaged in self-management support
7. Support and guidance in establishing and working towards a self-management goal is offered to every patient, including well patients
8. At least 1 member of PO or practice is formally trained through completion of nationally or internationally accredited prgm and work with staff per 11.1

12.0 Patient Web Portal

1. Available vendor options for purchasing and implementing a patient web portal system have been evaluated
2. PO or practice has assessed liability and safety issue involved in maintain a patient web portal at any level and developed system for secure info exchange
3. Ability for patients to request and schedule appointments electronically is activated and available to all patients
4. Ability for patients to log and graph results of self-administered patient data that indicated potential health issues
5. Providers are automatically alerted by system regarding self-administered patient data that indicates a potential health issue
6. Ability for patients to participate in E-visits is activated and available to all patients

13.0 Coordination of Care

1. For every patient with chronic condition selected for initial focus, mechanism is established for being notified of each patient admit and discharge
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
3. Approach is in place to systematically track care coordination activities for each patient with chronic condition selected for initial focus
4. Process is in place to systematically flag for immediate attention any issue that indicates a potentially time-sensitive issue with chronic condition
5. Process is in place to ensure that written transition plans are developed in collaboration with patient and their caregivers who are leaving the practice
6. Process in place to coordinate care with payer case manager for patients with complex or catastrophic conditions
7. Practice has written procedures and care team in trained on care coordination processes w/ defined roles
8. Care coordination capabilities are extended to all patients with chronic conditions that need care coordination asst.
9. Care coordination capabilities are extended to all patients that need care coordination assistance

14.0 Specialist Referral Process

1. Procedure in place to guide each phase of the specialist referral process including desired timeframes for appointment and information exchange for preferred or high volume specialist
2. Procedure in place to guide each phase of the specialist referral process including desired timeframes for appointment and information exchange when patients are referred to other key specialist
3. Directory is maintained listing specialist to whom patients are routinely referred
4. Practice organization or practice has developed specialist referral materials supportive of process and individual patient needs
5. Practice or designee routinely makes specialist appointments on behalf of patients
6. Each face of the interaction between preferred /high volume specialist any physician units level is automated w/electronically based tools or changing process
7. For all sub-spec visits deemed imp to the patients well being, process in place to determine whether or not patients completed referral, reasons for not, additional services recommended whether patient received those
8. Appropriate practice staff is trained in all aspects of the specialist referral process
9. Practice regularly evaluates patient satisfaction with most commonly used specialist, to ensure physicians are referring to specialist that meet their standards for patient centered care