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April 2021

Session 2

Patient Centered Medical Home: A Practice Model to Improve Quality

Kate Hill, VP Clinic Division

The Compliance Team®

Introductions

Kate Hill, R.N.
VP of Clinical Division

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Program Development Advisor

The Compliance Team

Session 2: Learning Objectives

- Quality Standards: PCMH 1.0 – 8.0, QI 1.0 – 2.0
- Universal and Specialty Standards (moved to Session 3)
- Policies, Templates and More Resources

REMINDER!

Register for Session 3 to complete the training series,
"Patient Centered Medical Home: A Practice Model to Improve Quality"

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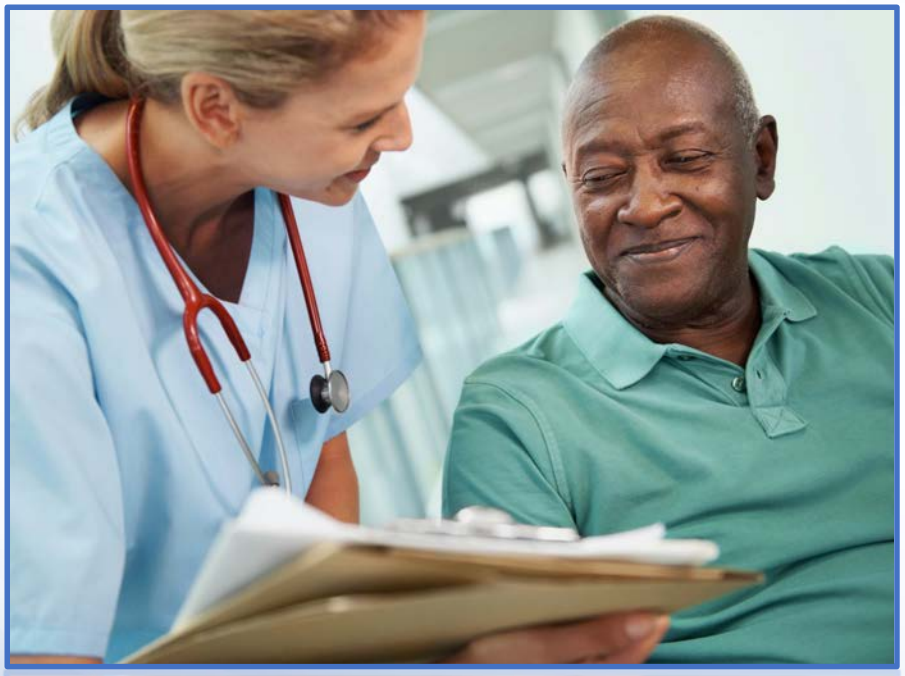
TCT Approach to PCMH



Simplification leads to clarity and clarity allows the provider to focus on what matters most to the patient!

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TheComplianceTeam™ Exemplary Provider® Accreditation

TCT Philosophy

"Operational excellence leads to clinical excellence!"

Sandy Canally, RN TCT CEO and Founder

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Disclaimer: PCMH Accreditation

For the purposes of this training, content, templates and accreditation information provided is exclusive to The Compliance Team Patient Centered Medical Home Program.

PCMH accreditation is offered by other accreditors and your clinic may want to research options before deciding which program best fits your needs.

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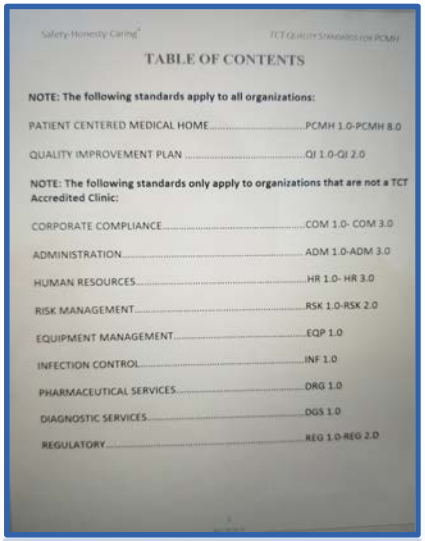
Use Session 1, Handout 3 for Standards Reference

In Session 1, Handout 3 we provided a copy of the PCMH Standards.

Please refer to Session 1, Handout 3 for the standards being presented in Session 2.

Universal and Specialty standards are included and will be presented in Session 3.

Difference between PCP and TCT RHC Accredited?



Answer:
Universal and Specialty Standards

- TCT RHC accredited clinics have already complied with Universal and Specialty standards as part of the RHC accreditation process
- PCMH standards include these additional standards as part of the process

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Who Should Be On The PCMH Implementation Team?

At a Minimum:
Clinic/Practice Manager and Care Coordinator

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First Steps First – Read the Standards

Knowledge is a powerful tool and understanding the PCMH model is only the beginning.

The next important step is read AND re-read the PCMH standards. Have a good working knowledge of the requirements before you begin.

When you have the first call with your Accreditation Advisor:

- ✓ Be ready to ask questions
- ✓ Ask for clarification if you are unsure of the intent of a standard
- ✓ Begin to formulate a preparation and implementation plan based off standards
- ✓ What are you doing already? What are you not doing? What needs to be part of your plan to initiate with staff?

Do You Have the Current PCMH Standards?

Look for REV 10.19.20
below the page number

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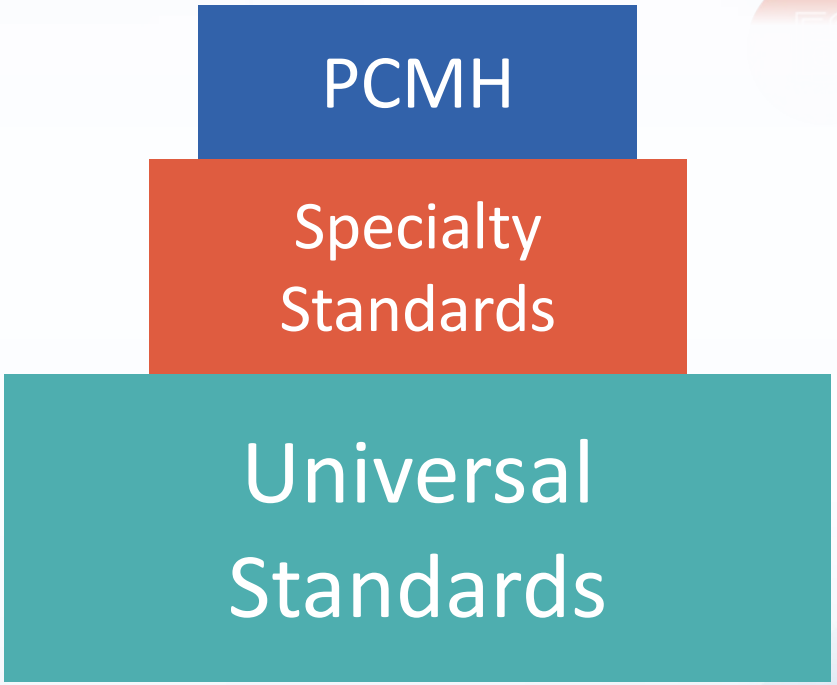
For Primary Care Practices…

PCMH requirements sit on top of The Compliance Team's Universal and Specialty Standards.



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What is a Patient Centered Medical Home?

Clearly, it's a journey not a destination!

Session 2, Part 1

TCT PCMH Standards
PCMH 1.0 – 8.0 and QI 1.0 – 2.0

Patient Centered Medical Home: A Practice Model to Improve Quality

Kate Hill, VP Clinic Division

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1.0 Team Based Coordinated Care

Providers, Nurses, Assistants, Clerical, and Administrative…

Everyone Working Together to Improve Overall Care

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PCMH 1.0

PCMH 1.0 - The organization utilizes a team-based approach for patient-centered coordinated care.

Evidence of Compliance

1) The organization's PCMH program follows a patient centered team-based process that includes the following:
   a. A description of the work-flow for all team members.
   b. Clearly defined lines of authority and team member responsibilities; and
   c. An organizational chart.

2) The organization ensures all new patients are:
   a. Assigned to a primary provider who is responsible for the patient's quality of care;
   b. Linked to a provider led care team; and
   c. Subsequent visits are provided by the same provider led care team, unless the primary provider orders a change, or the patient request a change.

3) All provider led care teams include at least one provider with the expertise to meet the needs of the targeted population.

The Art of the Huddle

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AMA Huddle Checklist

Team Huddle Checklist

Use this modifiable checklist to lead your team through efficient, effective huddles at the beginning of the clinic day or session.

Date:	Start time:
Huddle leader:	
Team members in attendance:	
Check in with the team	
	How is everyone doing?
	Are there any anticipated staffing issues for the day?
	Is anyone on the team out / planning to leave early / have upcoming vacation?
Huddle agenda	
	Review today's schedule
	Identify scheduling opportunities • Same-day appointment capacity • Urgent care visits requested • Recent cancellations • Recent hospital discharge follow-ups
	Determine any special patient needs for clinic day • Patients who are having a procedure done and need special exam room setup • Patients who may require a health educator, social work or behavioral health visit while at the practice • Patients who are returning after diagnostic work or other referral(s)
	Identify patients who need care outside of a scheduled visit
	Determine patient needs and follow up • Patients recently discharged from the hospital who require follow up • Patients who are overdue for chronic or preventive care • Patients who recently missed an appointment and need to be rescheduled
	Share a shout-out and/or patient compliment
	Share important reminders about practice changes, policy implementation or downtimes for the day
	End on a positive, team-oriented note • Thank everyone for being present at the huddle
	Huddle end time:

Source: AMA. Practice transformation series: implementing a daily team huddle. 2015.

Stand up

Meet 15 minutes before 1st patient arrives

Be consistent

Check in and announcements

Use visuals-Post agenda

Preview Patients

Identify potential challenges/concerns

Keep meeting short

Be courteous and respectful

Thank the team

Close the huddle

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Session 2, Handout 2

Please refer to Session 2, Handout 2 for information on

AMA Huddle Checklist

Patient Goals

PCMH 1.0

PCMH 1.0 - The organization utilizes a team-based approach for patient-centered coordinated care.

4) The organization has one or more designated staff members providing Care Coordination between Providers, other Healthcare Professionals, and patient care services provided externally.

    a. The Care Coordinator follows a process that addresses the following:
        i. Organizing and communicating clinical data to close the gaps in patient care transitions, thus supporting the continuity of care regarding patients and their providers' regarding orders/labs/diagnostics/referrals.
        ii. Working with patients/caregivers to develop written care goals.
        iii. Utilizing a system to identify and improve the care of high-risk or special needs patients. (e.g., huddles, communication boards, messaging, team meetings).
        iv. Utilizing written protocols with hospitals outlining the referral process and admission/discharge/transfer notifications.
        v. Providing a summary for patients transferring to another medical provider.
        vi. Providing support to patients/caregivers by helping them connect to community resources.
        vii. Transition Care Management Services (as applicable).

PCMH 1.0

PCMH 1.0 - The organization utilizes a team-based approach for patient-centered coordinated care.

5) The Care Coordinator monitors care provided to patients by other providers including:
   a. Specialists managing patient medications, ordering labs, diagnostics, treatments, procedures, and/or therapies.
   b. Pharmacists regarding patient medication history, adherence, and any involvement with medication therapy management

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PCHIP™ Patient Centered Health Improvement Plan™

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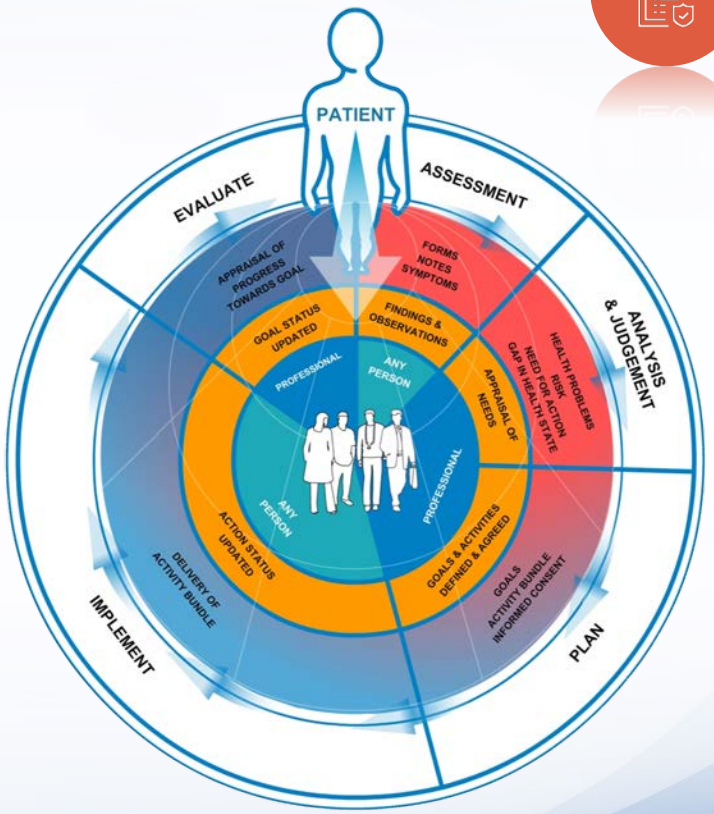
PCHIP™ Patient Centered Health Improvement Plan™

What is a PCHIP™ ?

A plan of Medical Care and support which…

- is unique to each patient and their specific needs
- is culturally and linguistically sensitive
- addresses the social determinants of health
- respects the patient's goal for optimal well-being



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PCMH 2.0

PCMH 2.0 - The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.

Evidence of Compliance

1. The organization follows a written policy and procedure for developing Patient-Centered Health Improvement Plans™ (PCHIP™) that address the current and future needs of the patient from a whole person perspective. This policy describes how the Care Team will:

    a. Identify high risk and/or complex patients in the practice.
    b. Provide patient communication and education to meet the unique needs of each patient. The PCHIP™ must address the following communication needs of the patient, if applicable:

        i. When a physical or mental impairment or learning disability exists;
        ii. When English is not the primary language spoken; or
        iii. When cultural or religious beliefs may impact the delivery of care.

PCMH 2.0

PCMH 2.0 - The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.

Evidence of Compliance — continued

c. When appropriate, include a patient's needs assessment concerning his/her ability to perform the activities of daily living, safety of the home environment, family/caregiver support, access to transportation, and other requirements for healthcare or support services that cannot be met by the organization.

d. Utilize a questionnaire or interview technique to identify and update the healthcare goal(s) most important from the patient's perspective. This questionnaire or interview determines the current limitations and frustrations that interfere with "what matters most" to the patient at this time in their life.

e. When appropriate, incorporate end-of-life or palliative care planning.

PCMH 2.0

PCMH 2.0 - The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.

1) Evidence exists that all members of the care team are trained to assess and address the needs of the patient from a whole patient perspective. Training addresses the following:

   a. The forms of communication and/or resources that allow for meaningful healthcare interactions and education;
   b. Indicators that prompt social support discussions and referrals;
   c. Short and long-term goal planning; and
   d. Indicators that prompt end-of-life or palliative care discussions.

Example: Care Plan Template

PATIENT-CENTERED CARE PLAN

Patient name: _____ Date: _____

Provider name: _____

Complete the next four sections prior to your visit:

Top concerns and barriers

The main things I would like to fix or improve about my health are:

-
-
-

The main things preventing me from improving my health are:

-
-
-

Symptom management

The main symptoms I wish to reduce or eliminate are:

-
-
-

To treat these, your provider will help you complete the "Summary of things I need to do," next page, at your appointment.

Online at AAFP.org

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Example: Care Plan Template

Summary of things I need to do

List action needed and time frame for each item. If not applicable, indicate N/A or none:

Tests to complete _____

Other health professionals to see _____

Community resources to use _____

Medication changes to make _____

Other treatments to get _____

Health-related education to pursue _____

Short-term activities to do _____

Lifestyle changes to make (for example, quit smoking, lose 10 pounds, buy a pedometer and walk 5,000 steps per day; goals – specific, measurable, achievable, realistic, time-bound – are recommended):

Diet _____

Exercise _____

Example: Patient Centered Goals

Patients' goals aren't always our goals.

What matters most to the patient?

What can be done to help them live their best life now?

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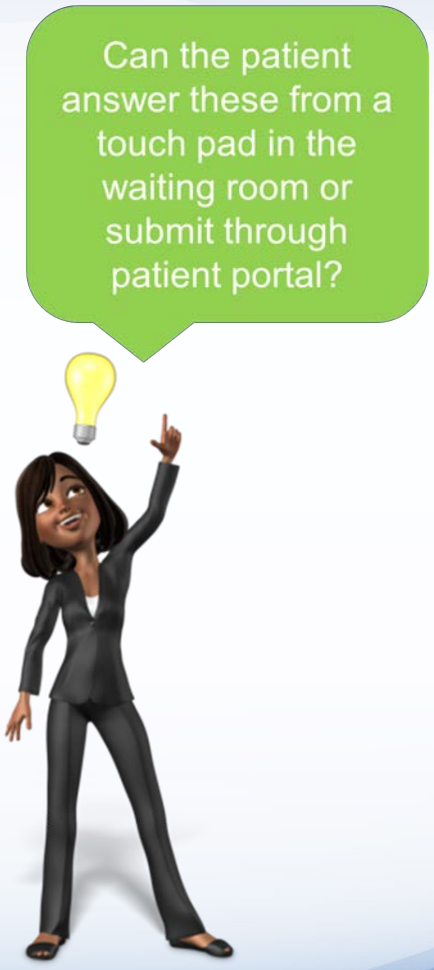
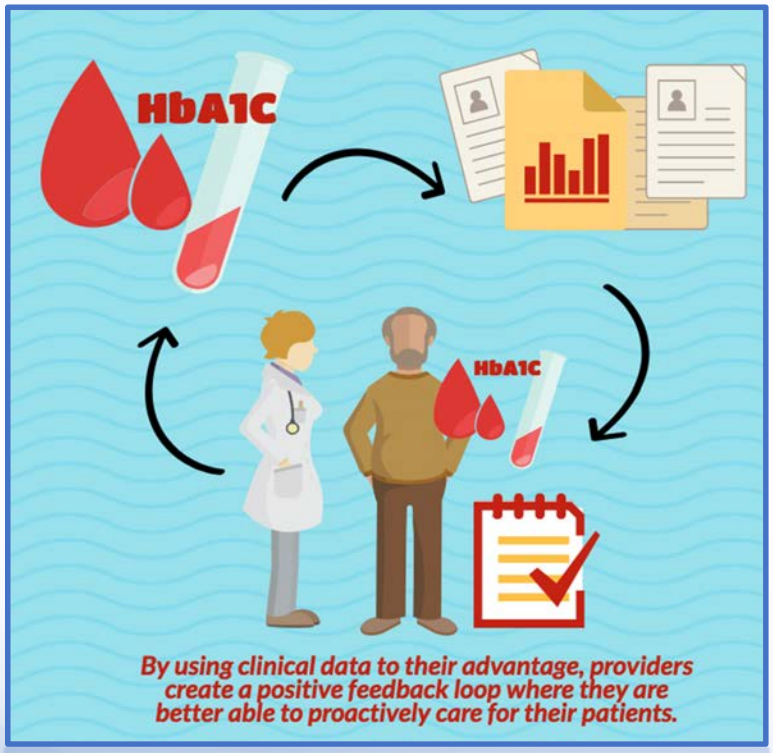
Goals and the EMR

1. **My goals to improve my health**: ***
2. **My healthcare team's goals**: ***
3. **My strengths and supports to meet my goals**: ***
4. **Challenges to meeting my goals**: *dropdown.*
   - Need more support
   - Housing problems
   - Transportation problems
   - Insurance problems
   - Healthcare providers don't speak my language
   - Legal problems
   - Financial problems
   - Other
5. **My healthcare team**: ***
6. **My Action Plan**: *dropdown.*
   - keep my appointments
   - if I feel worse, I will ***
   - take my medicines every day
   - Keep track of progress using ***
   - Other



Utilizing Clinical Data for Care Planning



The Organization Needs to Optimize the Use of EHR Technology to Manage Patient Populations

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PCMH 3.0

PCMH 3.0 - The organization provides patient education and self-management tools to patients and their family/caregivers.

Evidence of Compliance

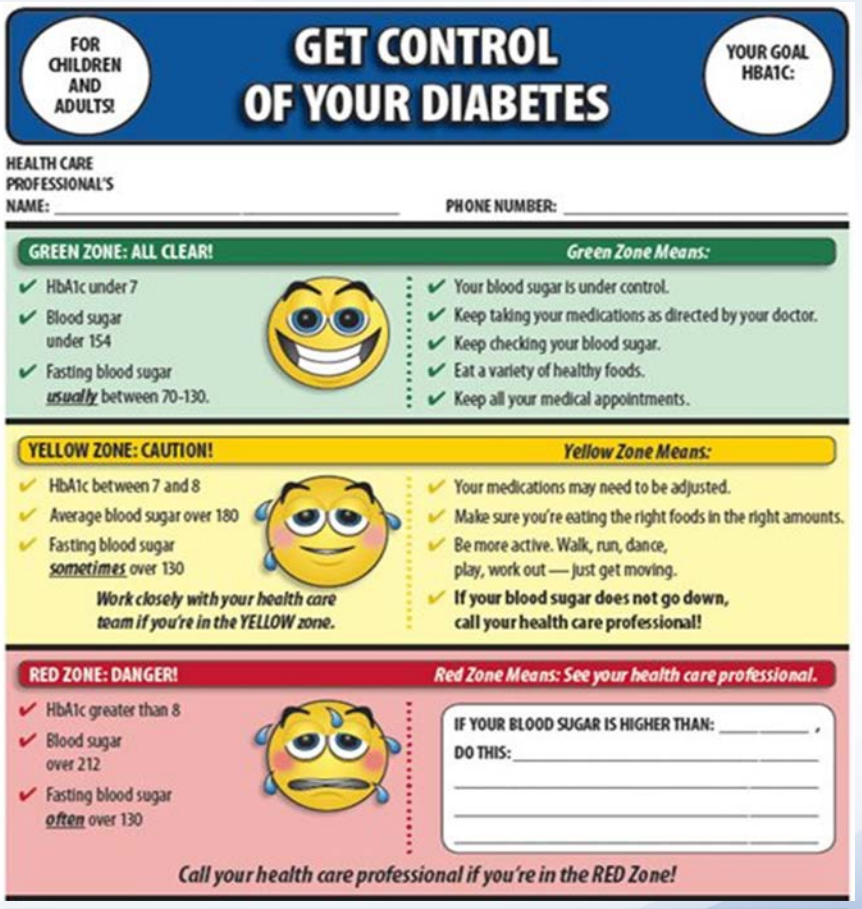
1) The organization provides patients, or when appropriate, the patient's representative (as allowed under State law) and their family/caregivers healthcare education and self-management tools when health problems are diagnosed, treatment is ordered, or risks are identified.

2) Evidence exists in the patient's healthcare record that the patient and their family/caregivers were provided healthcare education and self-management tools.

Educational tools empower patients to participate in their healthcare decisions resulting in better outcomes

Examples: Patient Education

Build a resource library of Patient Education tools that all providers can access.



FOR CHILDREN AND ADULTS!

GET CONTROL OF YOUR DIABETES

YOUR GOAL HBA1C:

HEALTH CARE PROFESSIONAL'S NAME: _____ PHONE NUMBER: _____

GREEN ZONE: ALL CLEAR!

- ✔ HbA1c under 7
- ✔ Blood sugar under 154
- ✔ Fasting blood sugar *usually* between 70-130.

Green Zone Means:

- ✔ Your blood sugar is under control.
- ✔ Keep taking your medications as directed by your doctor.
- ✔ Keep checking your blood sugar.
- ✔ Eat a variety of healthy foods.
- ✔ Keep all your medical appointments.

YELLOW ZONE: CAUTION!

- ✔ HbA1c between 7 and 8
- ✔ Average blood sugar over 180
- ✔ Fasting blood sugar *sometimes* over 130

Work closely with your health care team if you're in the YELLOW zone.

Yellow Zone Means:

- ✔ Your medications may need to be adjusted.
- ✔ Make sure you're eating the right foods in the right amounts.
- ✔ Be more active. Walk, run, dance, play, work out — just get moving.
- ✔ **If your blood sugar does not go down, call your health care professional!**

RED ZONE: DANGER!

- ✔ HbA1c greater than 8
- ✔ Blood sugar over 212
- ✔ Fasting blood sugar *often* over 130

Red Zone Means: See your health care professional.

IF YOUR BLOOD SUGAR IS HIGHER THAN: _____ ,
DO THIS: _____

Call your health care professional if you're in the RED Zone!

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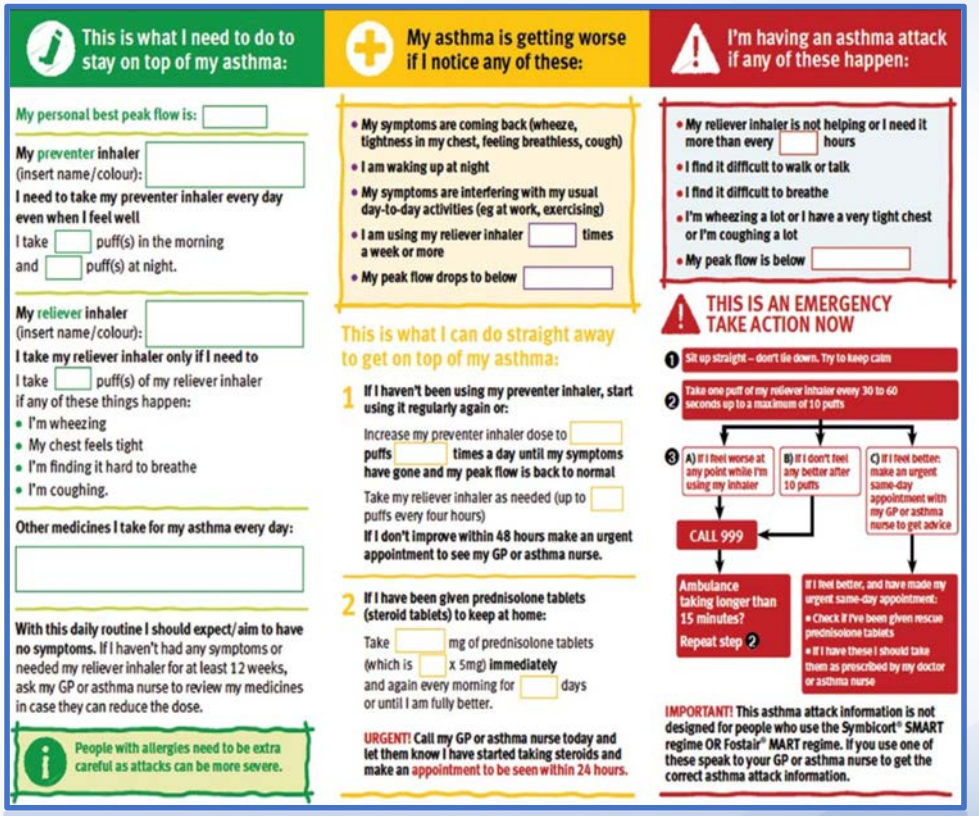
Examples: Patient Education

Periodically review educational tools to ensure they are up to date.



This is what I need to do to stay on top of my asthma:

My personal best peak flow is:

My preventer inhaler (insert name/colour):

I need to take my preventer inhaler every day even when I feel well

I take puff(s) in the morning and puff(s) at night.

My reliever inhaler (insert name/colour):

I take my reliever inhaler only if I need to

I take puff(s) of my reliever inhaler if any of these things happen:

- I'm wheezing
- My chest feels tight
- I'm finding it hard to breathe
- I'm coughing.

Other medicines I take for my asthma every day:

With this daily routine I should expect/aim to have no symptoms. If I haven't had any symptoms or needed my reliever inhaler for at least 12 weeks, ask my GP or asthma nurse to review my medicines in case they can reduce the dose.

People with allergies need to be extra careful as attacks can be more severe.

My asthma is getting worse if I notice any of these:

- My symptoms are coming back (wheeze, tightness in my chest, feeling breathless, cough)
- I am waking up at night
- My symptoms are interfering with my usual day-to-day activities (eg at work, exercising)
- I am using my reliever inhaler times a week or more
- My peak flow drops to below

This is what I can do straight away to get on top of my asthma:

1 If I haven't been using my preventer inhaler, start using it regularly again or:

Increase my preventer inhaler dose to puffs times a day until my symptoms have gone and my peak flow is back to normal

Take my reliever inhaler as needed (up to puffs every four hours)

If I don't improve within 48 hours make an urgent appointment to see my GP or asthma nurse.

2 If I have been given prednisolone tablets (steroid tablets) to keep at home:

Take mg of prednisolone tablets (which is x 5mg) immediately and again every morning for days or until I am fully better.

URGENT! Call my GP or asthma nurse today and let them know I have started taking steroids and make an appointment to be seen within 24 hours.

I'm having an asthma attack if any of these happen:

- My reliever inhaler is not helping or I need it more than every hours
- I find it difficult to walk or talk
- I find it difficult to breathe
- I'm wheezing a lot or I have a very tight chest or I'm coughing a lot
- My peak flow is below

THIS IS AN EMERGENCY TAKE ACTION NOW

1. Sit up straight – don't lie down. Try to keep calm
2. Take one puff of my reliever inhaler every 30 to 60 seconds up to a maximum of 10 puffs
3. A) If I feel worse at any point while I'm using my inhaler; B) If I don't feel any better after 10 puffs; C) If I feel better: make an urgent same-day appointment with my GP or asthma nurse to get advice

CALL 999

Ambulance taking longer than 15 minutes? Repeat step 2

If I feel better, and have made my urgent same-day appointment:
- Check if I've been given rescue prednisolone tablets
- If I have these I should take them as prescribed by my doctor or asthma nurse

IMPORTANT! This asthma attack information is not designed for people who use the Symbicort® SMART regime OR Fostair® MART regime. If you use one of these speak to your GP or asthma nurse to get the correct asthma attack information.

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4.0 Advanced Access and Community Resources

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PCMH 4.0

PCMH 4.0 - The organization provides advanced access to its patients.

Evidence of Compliance

1) The organization's provides advanced access by expanding hours of operation beyond traditional appointment hours. Increased patient access includes:

    a. Same day appointments for urgent illness;
    b. Evidence of expanded weekday, evening, and/or weekend appointment offerings; and
    c. Call coverage or arrangement for after-hours emergencies twenty-four hours a day and seven days a week.

2) The organization provides patients and their family/caregivers written information regarding the Patient-Centered Medical Home and its services. This information is available in the language(s) of the community served.

Meeting the Needs

The Organization Should Have Hours of Operation to Meet the Needs of the Population They Serve

Hours:

Monday-Thursday 7am-6pm

Friday 7am-4pm

Saturday 8am-noon, walk-in clinic only.

PCMH 4.0

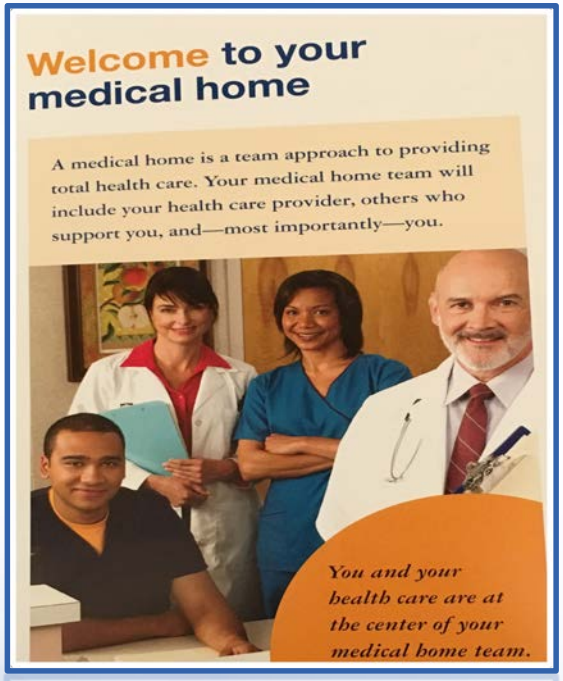
PCMH 4.0 - The organization provides advanced access to its patients.

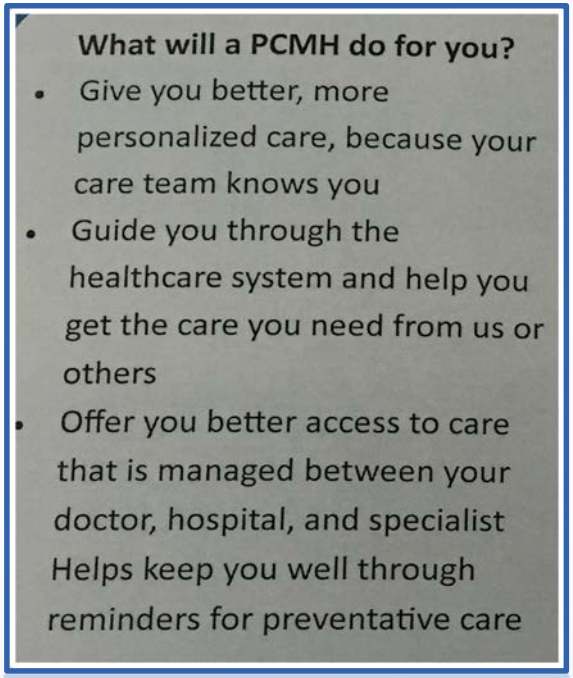
3) The organization communicates essential practice information to its patients. This information includes:

   a. What patients should bring to each appointment;
   b. How patient calls and prescription requests are handled;
   c. The routes in which patients can attain healthcare access after-hours; and
   d. Policies regarding the rescheduling or cancellation of appointments.

4) Evidence exists of advanced access through multiple forms of communication with its patients.

Examples

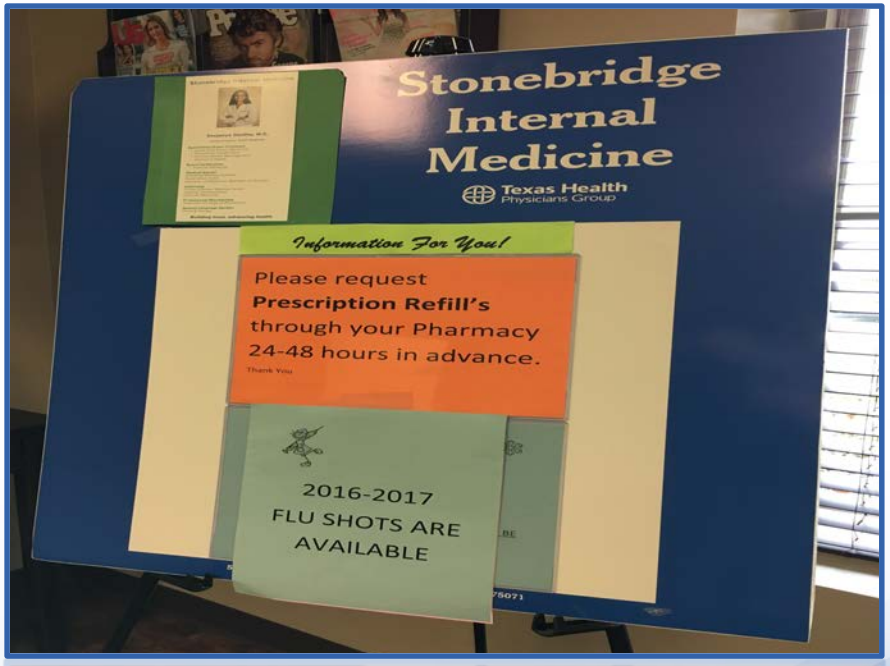




Patients Brochures Handed Out During Check-In Can Introduce the Concept of PCMH Before the Visit.

Examples

Waiting Room Posters Can Alert Patients To Community Resources or Seasonal Campaigns That Boost Compliance



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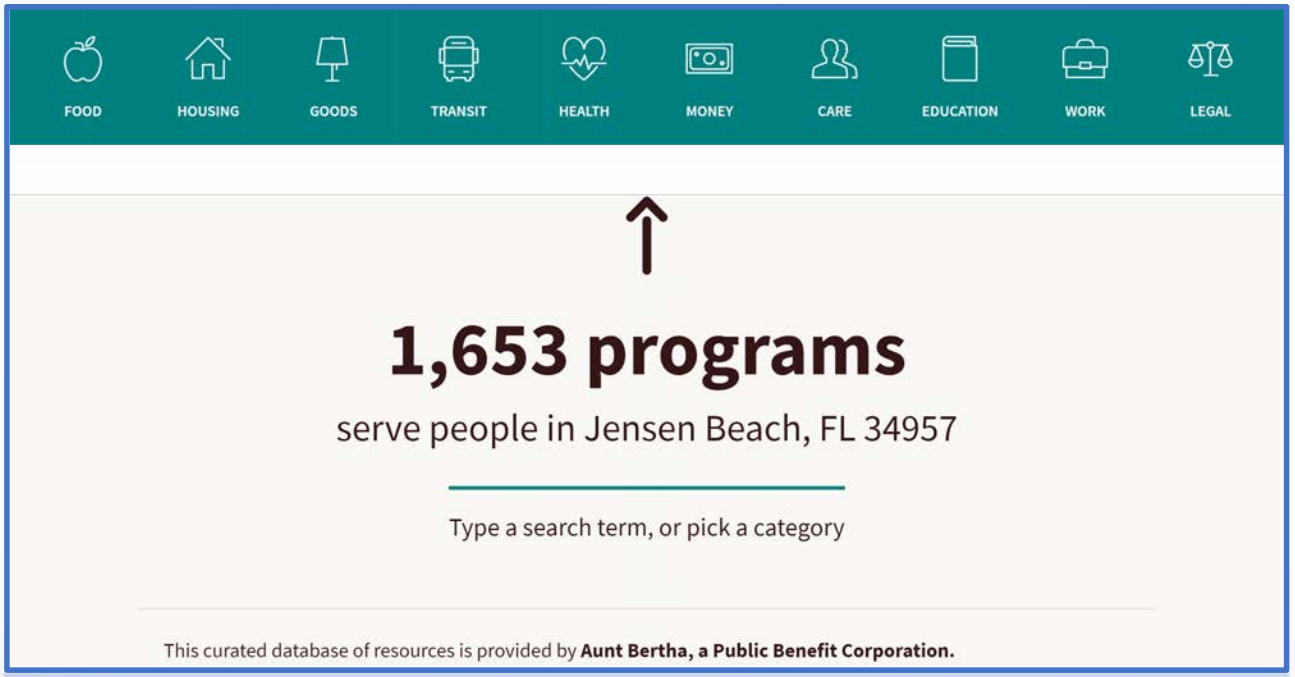
PCMH 4.0

PCMH 4.0 - The organization provides advanced access to its patients.

5) The organization follows a written plan for handling patient communication that includes acceptable time frames (as determined by organizational policy) for returning patient calls or requests. All calls or requests from patients are documented with a date and time.

6) Evidence exists that the organization actively engages with community resources to reach out to its patient population.

Community Resources: www.findhelp.org — Aunt Bertha



Helpful Tips

Build a List of Resources
That Are Available to Patients

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The Importance of Follow-Up Calls

Pro-active management and follow-up of high-risk or medically complex patients is proven to impact patient compliance. Patients/families report increased satisfaction with someone checking in on them.

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PCMH 5.0

1) To ensure continuity of care, the organization has a written policy and procedure for follow-up of their patients. The policy includes information on how the clinic provides follow-up information for:
    a. Missed patient appointments.
    b. Requests for medication refills by patients.
    c. High-risk medication(s) or in-home treatment(s) that are newly prescribed.
    d. Laboratory or diagnostic results.
    e. Referrals and consultations.
    f. Preventative care and screening reminders.
    g. Care coordination activities.
    h. Frequent use of the emergency department.
    i. Discharge from the hospital.
2) Evidence of follow-up communication with patients exists in the patient health record.

Bridge the Gaps to Look For Opportunities to Improve Care

Pro-active phone calls to patients after missed appointments, hospital discharges and ER visits.

Warm handoffs to other providers when a patient is being admitted or sent for referral.

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PCMH 6.0

PCMH 6.0 - The Organization meets the healthcare needs of patients when they are closed.

Evidence of Compliance

1) The organization has a written agreement with each contracted healthcare entity responsible for handling the needs of patient's after-hours. The agreement identifies the contracted provider's scope of services, HIPPA compliance, responsibilities for patient care, and after-hours of operation.

2) The organization's providers receive and review patient healthcare information from after-hours providers and evidence of this follow-up is documented in the patient health record.

3) The organization has a comprehensive process that provides patients the ability to communicate their healthcare needs after-hours.

Example: After Hours Communication

After-Hours Communication with Providers

a. For non-emergent medical needs, after hours, patients directed to call the hospital main line: INSERT NUMBER HERE. When a patient calls this number, they will speak to a hospital staff member 24/7.
    i. For medical emergencies, patients are directed to call 911.
b. When a patient calls the hospital after hours, the hospital staff will follow protocol and transfer the patient to most appropriate personnel.
    i. If hospital staff can answer the question, then they will direct patient.
    ii. If clinical staff is needed then phone call is transferred to clinical staff for triage.
c. Clinical staff will follow triage protocol and direct patient care as needed.
d. If patient is calling about emergency then patient is directed to emergency room.
e. If patient is triaged as non-emergent then patient is either:
    i. Scheduled for next business day office visit w/ appointment time and date
    ii. Or educated to call the next business day for appointment
f. Care after hours is charted in the EMR for care team to review.

PCMH 7.0

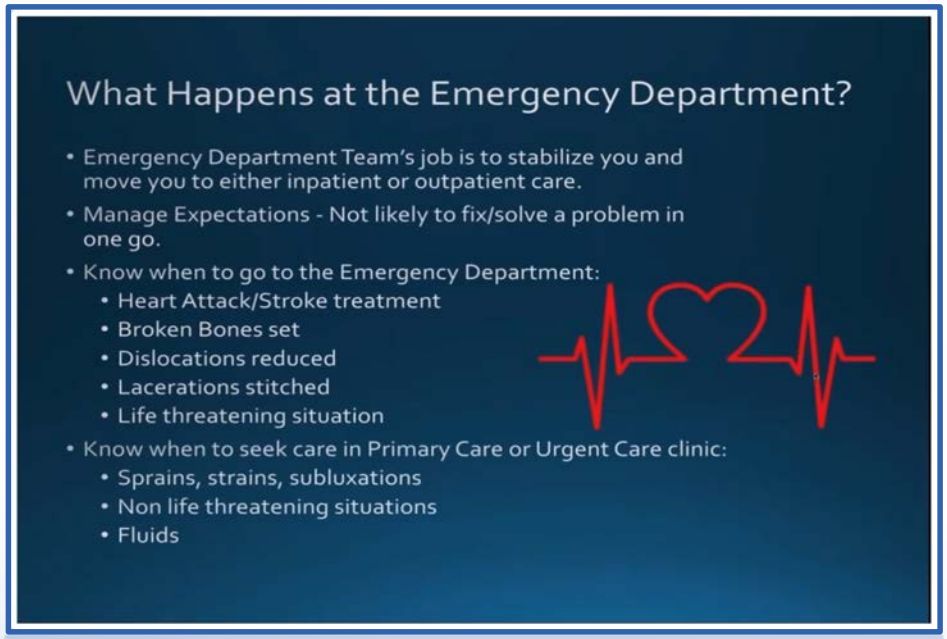
PCMH 7.0 - The organization takes steps to reduce unnecessary utilization of services.

Evidence of Compliance

1) To improve the efficiency in the delivery of care provided, the organization follows a written plan that prevents over utilization of services. This plan includes implementation of the following waste reduction initiatives:

    a. Reducing avoidable patient emergency department (ED) visits;
    b. Reducing patient hospital re-admissions; and
    c. Offering same-day appointments.

Example: ED Use



Signage in exam rooms can prompt discussions about calling PCMH before going to the ER

Helpful Tips

Teach patients about the <u>appropriate use</u> of the ER

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Getting it Right

Appropriate Utilization

is Providing

“the Right Care

at the Right Time

with the Right Provider”

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PCMH 7.0

PCMH 7.0 - The organization takes steps to reduce unnecessary utilization of services.

Evidence of Compliance

1) Evidence exists that the organization reports data on the following utilization of services quarterly to The Compliance Team:

   a. Number of patients requiring care coordination,
   b. Number of ED visits,
   c. Number of avoidable ED visits,
   d. Number of hospital admissions, and
   e. Number of hospital readmissions.

Example: Written Plan for improving efficiency

To support the PCMH philosophy, **INSERT PRACTICE NAME** takes efforts to reduce the unnecessary utilization of services (and expenditure of healthcare dollars) that increase cost without necessarily increasing benefit to the recipients. **INSERT PRACTICE NAME** will improve efficiency in the delivery of care to its PCMH patients by the following plan:

1. The PCMH will implement the following waste reduction initiatives:
    a. Utilizing generic medications whenever available and appropriate to the patient.
        i. Providers are asked to prescribe generic medications as a first line of treatment unless there is a medically necessary reason to avoid the generic alternative.
        ii. The organization is enrolled in the 340B program to help alleviate high cost of prescription medication. Eligible patients are made aware of the program.
    b. Reducing avoidable emergency department/after-hours urgent care visits.
        i. Providers and staff will take steps to identify patients that frequently seek care after PCMH business hours.
            1. State how your organization receives ED usage reports from healthcare systems
            2. State any health information exchanges that help identify these patients
            3. During patient check-in, ask if the patient has visited the ED within the past three months?

8.0 Patient Health Records

The Compliance Team™

PCMH 8.0

PCMH 8.0 - The organization ensures patient health records are complete.

1) The organization's patient health records have evidence of:
    a. Patient identification and social data that includes:
        i. Identification of the individual(s) included in the care and/or healthcare decisions of the patient; and
        ii. The preferred language to be used for healthcare discussions with patient's family members and caregivers.

    b. Written consent to treat for initiation of care and informed consent for medical procedures. Properly executed patient consents include:
        i. Date and time along with appropriate signature.
        ii. Identification of the signee's relationship for any patient under the age of majority or unable to given written consent for themselves.

PCMH 8.0

PCMH 8.0 - The organization ensures patient health records are complete.

c. Patient status regarding Advanced Directive, when appropriate:
   i. The organization asks the patient if they have an Advanced Directive.
   ii. If the patient does not have an Advanced Directive, the organization has evidence that the patient, or when appropriate, the patient's representative, was asked if they would like information.

d. Pertinent medical history.

PCMH 8.0

PCMH 8.0 - The organization ensures patient health records are complete.

e. Evaluation of current health status, which includes:

   i. Vital signs;

   ii. Gender, height, weight, and assessment of body mass index (BMI) or growth percentile;

   iii. Chief complaint;

   iv. Behavioral health screening when depressive symptoms are identified (e.g., Patient Health Questionnaire (PHQ 2 or 9) or another recognized tool);

   v. Cognitive health screening when symptoms are identified or if the patient is over 65 years of age (e.g., Brief Interview of Mental Status (BIMS) or another recognized tool);

   vi. Preventive-health measures;

   vii. Updated needs assessment (as appropriate);

   viii. Updated Patient-Centered Health Improvement Plan™ (PCHIP™) as appropriate and defined by the organization) ; and

   ix. Updated patient health goals (as appropriate and defined by the organization).

PCMH 8.0

PCMH 8.0 - The organization ensures patient health records are complete.

f. Summary of the encounter and patient instructions.

g. Reports, consultation notes, and any information pertinent to monitor the patient's progress.

h. Provider orders and documentation of tests, treatments, or medications administered in the practice setting.

i. Documentation and reconciliation of current patient medications (including supplements) and patient allergies.

j. Signature of the provider and date related to the encounter.

k. Identification of provider/care team assigned to the patient.

l. Identification of patient's pharmacy by name, location, and contact information. Note: Information may not be an individual field in electronic EMR but can be located in electronic prescribing software such as Escript®.

PCMH 8.0

PCMH 8.0 - The organization ensures patient health records are complete.

1) Patients are provided with a printed after-visit summary or it is available to them via the organization's patient portal. Note: If summaries are not provided to patients at checkout, the organization monitors the percentage of patients utilizing the portal to ensure this information is being utilized by their population. The after-visit summary includes:

    a. Current vital signs;
    b. Relevant health data;
    c. Current diagnosis;
    d. Current medications;
    e. Important patient instructions;
    f. Patient's short and long-term healthcare goals;
    g. Name of patient's provider; and
    h. PCMH contact Information.

Example: After Visit Summary

After Visit Summary
TEST,PATIENT
Visit date: 09/18/2013
Date generated: 09/22/2013 13:16
LOMA LINDA HCS

Department of Veterans Affairs

Today's Visit

Clinics Visited	• 13:30 - Dr. Byrne, Module 4 • 15:00 - Li/Surg/Pod/Wound Limb/Wed	
Providers	PROVIDER,JANE	
You Were Diagnosed With	• Essential hypertension • Obesity • Dyslipidemia • Cholelithiasis without obstruction • Smoker • Coronary arteriosclerosis	• Ankylosing spondylitis • Hypersomnia with sleep apnea • Dyspnea • Chronic obstructive lung disease • Diabetes mellitus type 2 • Gastroesophageal Reflux Disease
Vitals as of This Visit	• Blood Pressure: 128/54 • Body Mass Index: 34.58 • Pain: 7 • Pulse Oximetry: 96 (Room Air)	• Pulse: 66 • Respirations: 18 • Temperature: 98.1 F • Weight: 233.7 lb
Immunizations	• FLU,3 YRS	

New Orders From This Visit

Lab Tests

Please report to the lab for the following blood tests on the date listed for each test:

01/16/2014

- Basic Metabolic Panel (Chem 7) Blood Serum
- Hemoglobin A1c (Lab) Blood
- Lipid Profile Blood Serum
- Hepatic Function Panel Blood Serum

Other Orders

- Return To Clinic In 4 Months

- Vital signs
- Medications
- Labs
- Instructions
- Goals
- Follow up

PCMH 8.0

PCMH 8.0 - The organization ensures patient health records are complete.

3) Evidence exists, in QI Meeting minutes, that the organization:

a. Audit patient health records for completeness and accuracy. Audit results meet compliance with the number of records and frequency, as defined by organizational policy;

b. Analyzes data and reports findings to leadership; and

c. Identifies performance improvement opportunities and takes corrective action.

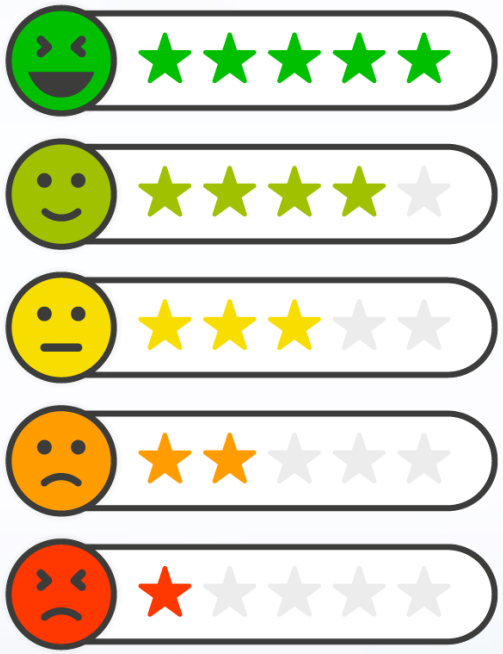
Is the Organization Providing:

Care that patients are satisfied with?

Better heath outcomes for the population?

Increased service from the practice?

Lower costs for overall care?



Here is where we find out…

The Compliance Team

QI 1.0

QI 1.0 - The organization collects data for patient satisfaction and dissatisfaction.

Evidence of Compliance

Patient Satisfaction Survey

1) The organization ensures a sample of patients receive a patient satisfaction survey. The patient sample size is determined by organizational policy.
2) The results of the patient satisfaction surveys are collected, evaluated and presented at QI/Staff meetings. Results are submitted to a national database for outcomes measurement.
3) The organization has a written policy and procedure to develop and implement corrective action if the result of the patient satisfaction evaluation reveals possible issues.

The Process for Surveying Patient Satisfaction Should Follow the Written Policy & Procedure

	Access, Delivery and Service	Yes	No	N/A
1	I received an appointment in a timely fashion.	☑	☐	☐
2	The person who answered the phone and made the appointment was courteous and helpful.	☑	☐	☐
3	The wait time to be seen by a provider was timely.	☑	☐	☐
4	The services I received were appropriate and addressed my needs.	☑	☐	☐
5	My appointment needs were handled in a confidential and professional manner.	☑	☐	☐
6	My medical questions were answered and addressed in a way that I understood.	☑	☐	☐
7	I have been informed and understand my diagnosis.	☑	☐	☐
8	I have been informed of and understand the treatment plan.	☑	☐	☐
9	All of the staff that I interacted with treated me respectfully and professionally.	☑	☐	☐
10	I was 100% satisfied with my overall experience and the health services provided.	☑	☐	☐

QI 1.0

QI 1.0 - The organization collects data for patient satisfaction and dissatisfaction.

Complaints

4) The organization has a written policy and procedure for defining, handling, reviewing and resolving complaints.

5) The organization provides its patients with written information on the complaint process, which includes the statement " In the event your complaint remains unsolved with **<organization name>**, you may file a complaint with our accreditor, The Compliance Team, Inc. via their website (www.thecomplianceteam.org) or via phone 1-888-291-5353."

6) When a complaint is received, the organization provides notice to the complainant that the issue is being investigated within the timeframe identified in the organization policy.

Complaints

Patients Need to Have Access to The Compliance Team's Contact Information Should They Need to File a Complaint.

In the event your complaint remains unresolved with (name of practice) you may file a complaint with our accreditor, The Compliance Team via the website — www.thecomplianceteam.org or by calling **1-800-291-5353**.

This may be posted or on a complaint form

The Compliance Team

QI 2.0

QI 2.0 - The organization performs an annual evaluation of its written policies and procedures for continuous quality improvement. Findings are evaluated to ensure it is following the guiding principles of the Patient-Centered Medical Home Model.

1) The organization has written policies and procedures outlining its Quality Improvement (QI) activities. The policies and procedures include the following:

   a. Designating a staff member for oversight of the QI activities.
   b. Monitoring the following:

      i. Completeness/accuracy of patient health records (random chart audit volume and frequency will be determined by organizational policy);
      ii. Compliance with preventive-health measures (as required by Medicaid or third-party payers);
      iii. Compliance with the continuity of care process (which addresses the coordination of care regarding patient appointments and provider orders/labs/diagnostics/referrals) that close the gaps in patient care transitions;

QI 2.0

QI 2.0 - The organization performs an annual evaluation of its written policies and procedures for continuous quality improvement. Findings are evaluated to ensure it is following the guiding principles of the Patient-Centered Medical Home Model.

iv. Incident reporting;

v. Patient satisfaction data;

vi. Number of same day appointments (which addresses increased patient access);

vii. Number of patients being identified as high-risk and/or complex, for which the PCMH is pro-actively managing. "High-risk and/or complex" is defined by organizational policy.

viii. Percentage of generic medications prescribed; and

ix. Number of emergency department visits by high-risk and/or complex patients who visit the emergency department frequently. “Frequently” is defined by organizational policy clarifying the number of visits within a timeframe.

x. Number of patients followed-up after discharge from the hospital (as determined by Admission/Discharge/Transfer reporting).

QI 2.0

QI 2.0 - The organization performs an annual evaluation of its written policies and procedures for continuous quality improvement. Findings are evaluated to ensure it is following the guiding principles of the Patient-Centered Medical Home Model.

c. Analyzing data and reviewing findings with key leadership at least quarterly.

d. Identifying performance improvement opportunities and taking corrective action when needed.

e. Communicating changes throughout the organization.

f. Following-up to ensure the desired change is achieved through the corrective action(s).

Written Policy for Describing the QI Activities of the PCMH

- **Data Informed Practice**. Successful QI processes create feedback loops, using data to inform practice and measure results. Fact-based decisions are likely to be correct decisions.
- **Statistical Tools**. For continuous improvement of care, tools and methods are needed that foster knowledge and understanding. CQI organizations use a defined set of analytic tools such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms, and control charts to turn data into information.
- ***Prevention Over Correction***. Continuous Quality Improvement entities seek to design good processes to achieve excellent outcomes rather than fix processes after the fact.
- ***Continuous Improvement***. Processes must be continually reviewed and improved. Small incremental changes do make an impact, and providers can almost always find an opportunity to make things better.

Policy Templates are provided as part of the TCT PCMH Accreditation Package

The Compliance Team

QI 2.0

QI 2.0 - The organization performs an annual evaluation of its written policies and procedures for continuous quality improvement. Findings are evaluated to ensure it is following the guiding principles of the Patient-Centered Medical Home Model.

2) Annually, the organization performs a program evaluation to:

   a. Review the following:
      i. Utilization review of all services provided by the PCMH;
      ii. The number of patients served and volume of services;
      iii. Organizational policies and procedures; and
      iv. Trends from the past year's QI data (as defined in QI 2.0.1(b)(i-x).

QI 2.0

QI 2.0 - The organization performs an annual evaluation of its written policies and procedures for continuous quality improvement. Findings are evaluated to ensure it is following the guiding principles of the Patient-Centered Medical Home Model.

b. Determine whether the PCMH plan supports compliance with the guiding principles of PCMH which includes improved patient access, team-based care approach, care coordination, utilization of the PCHIP™, and patient follow-up. The organization creates and uses a simple self-assessment checklist for this purpose.

c. Make changes to the PCMH plan as required.

3) Evidence exists of the QI data collection and analysis, findings, action-plans, follow-up, and the annual PCMH program evaluation.

Annual Program Evaluation

The purpose of this document is to summarize the administrative, personnel, and fiscal activities of PRACTICE NAME for the period XX/XX/XXXX through XX/XX/XXXX. The evaluation shall determine if the utilization of services was appropriate, the established policies and procedures were followed, and evaluate the need to change or revise the program.

Utilization of Services

- PRACTICE NAME had NUMBER patient visits during the fiscal year with NUMBER patients being seen.
- Payer Distribution:
  - XX% Medicare
  - XX% Medicaid
  - XX% Private Insurance
  - XX% Workers Compensation
  - XX% Self-Pay
  - XX% Other

Helpful Tips

Template included as part of the TCT PCMH Accreditation Package.

The Compliance Team

PCMH QI Audit Tool

INSERT PRACTICE NAME
PCMH Quality Improvement Plan Audit Tool
INSERT DATE HERE
Completed By: INSERT NAME

Audit Tool Instructions: Insert an "X" under YES noting the organization is in full compliance, under PARTIAL if it is in partial compliance, or under NO if the organization is not in compliance with any of the elements at this time. Insert notes into the far-right column to explain PARTIAL or NO findings.

Advanced Access to Patients	Standard	Yes	Partial	No	Notes
Evidence of Improved Access of Patients to Services: • Same day appointments available for urgent illness?	PCMH 1.0				
• Expanded patient care hours (e.g., early morning, during lunch hours, evenings, and/or weekends)?	PCMH 1.0				Current Business Hours:
• The organization engages with community resources to reach out to its patient population?	PCMH 1.0				Describe Outreach:
• Call coverage or arrangement for after-hours emergencies 24 hours a day and 7 days a week?	PCMH 2.0				Describe Coverage:
					Any "Partial" or "No" mark should be addressed at the end of the audit tool under performance improvement action plans.
Team-Based Approach for Care	**Standard**	**Yes**	**Partial**	**No**	**Notes**
Evidence of Provider-Led Care Team(s) • Patients are assigned to a specific Care Team?	PCMH 3.0				
• Consistency of patient appointments within the same Care Team?	PCMH 3.0				
Evidence of Enhanced Communication within Care Team • Huddles/Communication Boards/Meetings?	PCMH 3.0				
Evidence of Designated Care Coordinator working interdependently with Providers (internal & external) • Coordination/Follow-Up with Specialists, Other Providers, and Pharmacists?	PCMH 3.0				Current Number of Patients Being Followed by Care Coordinator:
• PCHIPS™ Initiated for all Patients Needing Care Coordination?	PCMH 7.0				

Templates are included as part of the TCT PCMH Accreditation Package.

The Compliance Team

Important Reminder!

Your organization must be functioning as a Patient Centered Medical Home on the date of survey!

The Compliance Team™

Session 2, Part 2

Policies, Templates and More

Patient Centered Medical Home: A Practice Model to Improve Quality

The Compliance Team™

Policies, Templates and More Resources

Available as part of the accreditation package, TCT has a wide range of resources for the Patient Centered Medical Home program including:

Webinars

Templates for Policies and Procedures

Patient Satisfaction Survey Portal

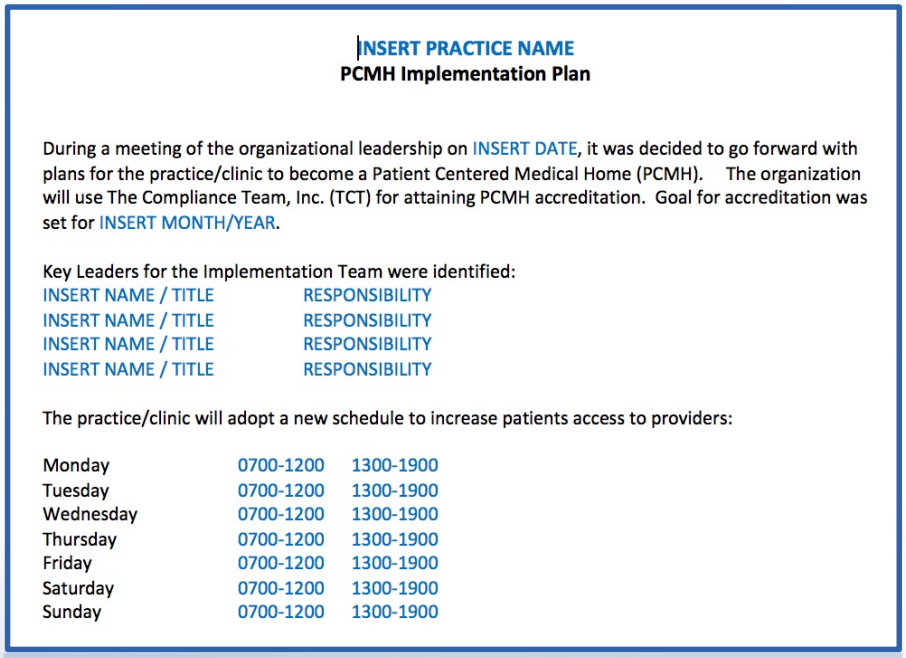
Quality Measures Portal

Individual support with an Accreditation Advisor

**Important to Note: Other accreditors have developed their own PCMH standards and resources may or may not be provided.

The Compliance Team®

Resources: Sample PCMH Templates



INSERT PRACTICE NAME
PCMH Implementation Plan

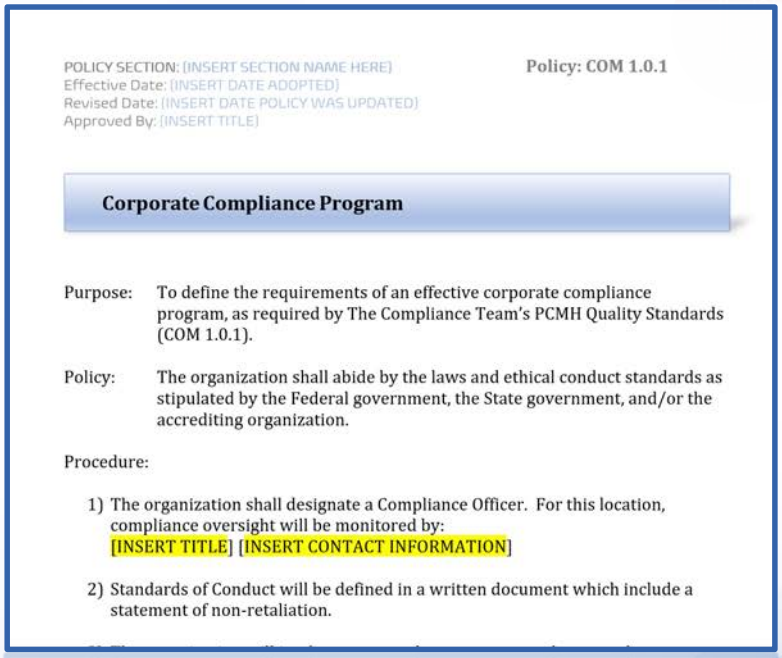
During a meeting of the organizational leadership on INSERT DATE, it was decided to go forward with plans for the practice/clinic to become a Patient Centered Medical Home (PCMH). The organization will use The Compliance Team, Inc. (TCT) for attaining PCMH accreditation. Goal for accreditation was set for INSERT MONTH/YEAR.

Key Leaders for the Implementation Team were identified:

INSERT NAME / TITLE	RESPONSIBILITY
INSERT NAME / TITLE	RESPONSIBILITY
INSERT NAME / TITLE	RESPONSIBILITY
INSERT NAME / TITLE	RESPONSIBILITY

The practice/clinic will adopt a new schedule to increase patients access to providers:

Monday	0700-1200	1300-1900
Tuesday	0700-1200	1300-1900
Wednesday	0700-1200	1300-1900
Thursday	0700-1200	1300-1900
Friday	0700-1200	1300-1900
Saturday	0700-1200	1300-1900
Sunday	0700-1200	1300-1900



POLICY SECTION: (INSERT SECTION NAME HERE) Policy: COM 1.0.1
Effective Date: (INSERT DATE ADOPTED)
Revised Date: (INSERT DATE POLICY WAS UPDATED)
Approved By: (INSERT TITLE)

Corporate Compliance Program

Purpose: To define the requirements of an effective corporate compliance program, as required by The Compliance Team's PCMH Quality Standards (COM 1.0.1).

Policy: The organization shall abide by the laws and ethical conduct standards as stipulated by the Federal government, the State government, and/or the accrediting organization.

Procedure:

1) The organization shall designate a Compliance Officer. For this location, compliance oversight will be monitored by:
[INSERT TITLE] [INSERT CONTACT INFORMATION]

2) Standards of Conduct will be defined in a written document which include a statement of non-retaliation.

The Compliance Team™

PCMH – Session 2, Handout 1

Refer to Session 2, Handout 1

Sample Template for PCHIP

3rd Party Website Resources for PCMH

The Compliance Team

Clinic Perspective

A Discussion with a PCMH Clinic Director

April 2021

The Compliance Team™

Thank You For All You Do!

The Compliance Team

Join us on

Thursday, April 8,2021 for Session 3!

Thank you!

QUESTIONS?

Kate Hill, RN, VP Clinic Division

215-654-9110

khill@thecomplianceteam.org

The Compliance Team®

Patient Centered Medical Home: A Practice Model to Improve Quality

Session 2, Handout 1

Sample Templates:

POLICY SECTION: [INSERT SECTION NAME] Policy: PCMH 2.0.1
Effective Date: [INSERT DATE ADOPTED]
Revised Date: [INSERT DATE POLICY WAS UPDATED]
Approved By: [INSERT TITLE]

Utilization of a Patient Centered Health Improvement Plan

Purpose: To define the utilization of a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated, as required by The Compliance Team's PCMH Quality Standards (PCMH 2.0.1).

Policy: The organization shall abide by the laws and ethical conduct standards as stipulated by the Federal government, the State government, and/or the accrediting organization.

Procedure:

1) The organization creates a Patient-Centered Health Improvement Plans™ (PCHIP™) which addresses the current and future needs of the patient from a whole person perspective. The Care Team will:
    a. Identify high risk and/or complex patients in the practice. [State how the organization identifies high risk/complex patients]
    b. Provide patient communication and education through the formats identified to meet the unique needs of each patient.
    c. The PCHIP™ addresses the communication needs of the patient:
        i. When a physical or mental impairment or learning disability exists;
        ii. When English is not the primary language spoken; or
        iii. When cultural or religious beliefs may impact the delivery of care.
2) When appropriate, perform a patient's needs assessment concerning ability to perform the activities of daily living, safety of the home environment, family/caregiver support, access to transportation, and other requirements for healthcare or support services that cannot be met by the organization. [Define the organization policy on when a needs assessment is appropriate]
3) Utilize a questionnaire or interview technique to identify and update the healthcare goal(s) most important from the patient's perspective. [Identify questionnaire or interview technique the organization will utilize]
4) When appropriate, incorporate end-of-life or palliative care planning.

INSERT PRACTICE NAME

Care Coordination Procedures

PURPOSE: To develop a written protocol for Care Coordination within the PCMH

POLICY: The Care Coordinator Needs To:

- Assist all patients through the healthcare system by acting as a patient advocate and navigator.
- Participate in Patient-Centered Medical Home team meetings and quality improvement initiatives.
- Support patient self-management of disease and behavior modification interventions.
- Emphasize continuity of care to reduce fragmentation, duplication, and/or gaps in treatment plans with external healthcare organizations and facilities. This includes the process of hospital admissions/discharges and referrals from the primary care provider to specialty care providers.
- Coordinate continuity of patient care with patients and families following hospital admission, discharge, and ER visits.
- Manage high risk patient care, including management of patients with multiple co-morbidities or high risk for readmission to a hospital setting.
- Manage or oversee activities utilizing the data from a registry.
- Identify opportunities for health promotion and illness prevention.
- Oversee Medicare Wellness Visits (MWV) for patients

3rd Party Resources:

Website Resources for RHC/PCMH

Community Resources

Aunt Bertha https://www.auntbertha.com

Disease Control and Prevention

CDC www.cdc.gov

Emergency Preparedness

ASPR Tracie https://asprtracie.hhs.gov

PCMH Resource Center

AHRQ https://pcmh.ahrq.gov

Care Plans

https://www.youtube.com/watch?v=4OFbbmyowFc

Needs Assessment

https://www.ahrq.gov/sites/default/files/publications/files/health-assessments_0.pdf

Cognitive Assessment

https://www.mocatest.org

Patient Self Management

IHI http://www.ihi.org/resources/Pages/Changes/SelfManagement.aspx

CDC https://www.cdc.gov/learnmorefeelbetter/index.htm

Patient Centered Medical Home: A Practice Model to Improve Quality

Session 2, Handout 2

Example: Patient Goals

1. **My goals to improve my health**: ***
2. **My healthcare team's goals**: ***
3. **My strengths and supports to meet my goals**: ***
4. **Challenges to meeting my goals**: *dropdown.*
   - Need more support
   - Housing problems
   - Transportation problems
   - Insurance problems
   - Healthcare providers don't speak my language
   - Legal problems
   - Financial problems
   - Other
5. **My healthcare team**: ***
6. **My Action Plan**: *dropdown.*
   - keep my appointments
   - if I feel worse, I will ***
   - take my medicines every day
   - Keep track of progress using ***
   - Other

AMA Steps Forward Sample Team Huddle Checklist

Team huddle checklist

Use this modifiable checklist to lead your team through efficient, effective huddles at the beginning of the clinic day or session.

Date:	Start time:
Huddle leader:	
Team members in attendance:	
Check in with the team	
	How is everyone doing?
	Are there any anticipated staffing issues for the day?
	Is anyone on the team out / planning to leave early / have upcoming vacation?
Huddle agenda	
	Review today's schedule
	Identify scheduling opportunities • Same-day appointment capacity • Urgent care visits requested • Recent cancellations • Recent hospital discharge follow-ups
	Determine any special patient needs for clinic day • Patients who are having a procedure done and need special exam room setup • Patients who may require a health educator, social work or behavioral health visit while at the practice • Patients who are returning after diagnostic work or other referral(s)
	Identify patients who need care outside of a scheduled visit
	Determine patient needs and follow up • Patients recently discharged from the hospital who require follow up • Patients who are overdue for chronic or preventive care • Patients who recently missed an appointment and need to be rescheduled
	Share a shout-out and/or patient compliment
	Share important reminders about practice changes, policy implementation or downtimes for the day
	End on a positive, team-oriented note • Thank everyone for being present at the huddle
	Huddle end time:

Source: AMA. Practice transformation series: implementing a daily team huddle. 2015.