Click here to view PRESENTATION RECORDING.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $205,000 (25 percent) funded by HRSA/HHS and $615,000 (75 percentage) funded by nongovernment sources through an award with the Missouri Department of Health and Senior Services, Office of Rural Health and Primary Care (DHSS, ORHPC). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA/HHS, or the U.S. Government.

April 2021

Session 3

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

Theresa Griffin Rossi
Program Development Advisor

The Compliance Team

Session 3: Learning Objectives

- Universal and Specialty Standards
- Implementing the Model
- Conducting a Mock Survey

The Compliance Team™

TheComplianceTeam™ Exemplary Provider® Accreditation

TCT Philosophy

"Operational excellence leads to clinical excellence!"

Sandy Canally, RN TCT CEO and Founder

TheComplianceTeam™

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.

The Compliance Team®

Use Session 1, Handout 3 for Standards Reference

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

Universal and Specialty Standards are included in that handout.

Please refer to Session 1, Handout 3 for the Universal and Specialty standards being presented in Session 3.

TheComplianceTeam®

Do You Have the Current PCMH Standards?

Look for REV 10.19.20
below the page number

The Compliance Team®

Session 3, Part 1

TCT Universal and Specialty Standards

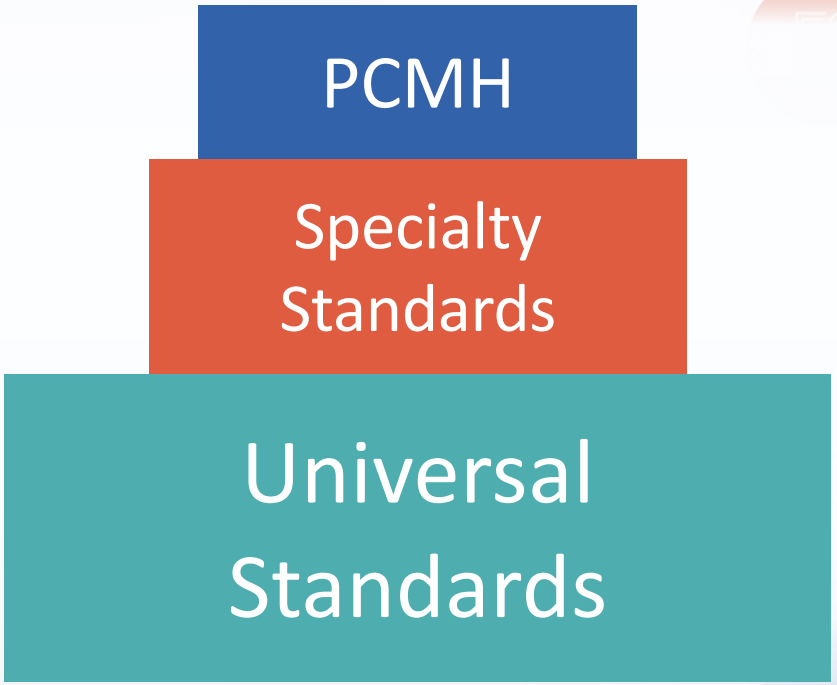
Patient Centered Medical Home: A Practice Model to Improve Quality

Kate Hill, VP Clinic Division

The Compliance Team™

For Primary Care Practices…

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



The Compliance Team®

Universal Quality Standards

Corporate Compliance

Administration

Human Resources

Quality Improvement

Risk Management

The Compliance Team™

COM 1.0

COM 1.0 - The organization has a Corporate Compliance plan.

Evidence of Compliance

1) The organization has written policies and procedures required for an effective compliance program that include the following:
   a. Designating a Compliance Officer;
   b. Having written Standards of Conduct that include a non-retaliation statement;
   c. Following procedures to prevent, detect, and correct Fraud, Waste, and Abuse;
   d. Performing a Risk Assessment that addresses areas of vulnerability;
   e. Utilizing continuous Quality Improvement techniques (e.g. auditing, problem identification, investigation, and corrective action); and
   f. Following disciplinary and corrective action plans when non-compliance is suspected.
2) Evidence exists that staff has been trained on all elements of the Corporate Compliance Plan upon-hire and annually. When interviewed, staff is knowledgeable of the Standards of Conduct for the organization.

COM 2.0

COM 2.0 - The clinic is in good standing with the Medicare/Medicaid Programs.

Evidence of Compliance

1) The organization, which participates in the Medicare/Medicaid program, has been free of sanctions for a period of at least 2 years.

2) The organization takes steps at on-boarding (and annually) to prohibit the employment or contracting of individuals or companies that have been convicted of a criminal felony offense related to healthcare.

    a. There is evidence of verification of individuals through the OIG exclusion database, www.oig.hhs.gov .

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

The Compliance Team

Online Resource

Welcome to the Office of Inspector General

www.oig.hhs.gov

The Compliance Team

COM 3.0

COM 3.0 - The organization's staff are licensed, certified, or registered in accordance with applicable State laws.

Evidence of Compliance

1) The organization has a written process verifying applicable personnel are licensed, certified, or registered, as required by State law.

2) This information is documented and tracked in an organized format.

ADM 1.0

ADM 1.0 - The organization has a governing body or individual having legal responsibility for the conduct of the organization.

Evidence of Compliance

1) The organization has proof of ownership.
2) The organization reports any change in ownership to The Compliance Team.
3) The organization has an organizational chart.
4) The organization has a protocol that identifies who is in charge of day-to-day operations in the absence of key leadership.

ADM 2.0

ADM 2.0 - The organization follows written policies and procedures for the maintenance of patient health records.

Evidence of Compliance

1) The organization has written policies and procedures to ensure patient health records are maintained in accordance with policy. The policies include:

    a. Having a patient health record for every person receiving services by the organization.
    b. Designating a member of the organization's professional staff who is responsible for the maintenance of patient health records by ensuring they are:

        i. Complete and accurately documented.
        ii. Readily accessible and systematically organized.
        iii. Complete when patients are referred or transferred.

ADM 3.0

ADM 3.0 - The organization follows written policies and procedures addressing protected health information.

Evidence of Compliance

1) The organization has written policies and procedures addressing protected health information (PHI) that address the use, security, and removal of patient health records as required by current HIPAA regulations. The policies and procedures include:
    a. Describing the steps taken by staff to ensure a patient's privacy during the provision of service and on-going confidentiality is maintained;
    b. Ensuring safeguards are in place to protect health information against loss, destruction, and unauthorized use;
    c. Publicly posting a privacy notice and making it available to all patients at time of initial contact;
    d. Requiring a patient's consent for the release of PHI before any information not authorized by law is released;
    e. Ensuring Business Associate Agreements (BAA) are in place when an entity or contractor, having access to PHI, is engaged by the organization; and
    f. Maintaining patient health records, at a minimum, 6 years from the last date of entry or longer if required by State statute.
2) Evidence exists that all staff is trained on patient privacy, confidentiality, and HIPAA regulations upon-hire and annually.

HR 1.0

HR 1.0 - The organization follows written policies and procedures for hiring, orienting, and training all staff.

Evidence of Compliance

1) The organization has written policies and procedures for human resources that are consistent with the needs for the services it provides to its beneficiaries. The policies include:
   a. Specifying personnel qualifications and experience requirements.
   b. Specifying training, competency, and continuing education requirements.

2) Evidence exists of staff training and validation of competency upon hire, annually, when new services are added, or when a staff member's performance warrants it.

HR Audit – Licensed Staff Members

Licensed Staff Member	State of Origin License # (or Certificate #)	License Expiration Date	DEA Certificate # (as applicable)	DEA Expiration Date	BLS Expiration Date For Licensed and Certified Patient Care Personnel

Medical Director
Providers
Registered Nurses
Licensed Nurses
Certified Medical Assistants
Radiology Technologists

TCT Requirement:
All licensed or certified staff must have BLS certification. ACLS or PALS also acceptable.

The Compliance Team

Ensure HR Files are Complete for Clinic Staff and Providers

Facility Name/Clinic:	Survey Date:	
Total Number of Exam Rooms:	Time In:	Time Out:

NOTE: DEFICIENCIES IDENTIFIED DURING THE HUMAN RESOURCES FILE REVIEW ARE CITED UNDER HR 3.0

Personnel File Audit Tool
Insert "Y" (YES) if evidence is found, "N" (NO) if evidence of is missing, or "NA" if not applicable.

Staff Member	Application Resume or CV	I-9 and W-4 For Employees	OIG Exclusion	Signed Job Description	Signed Standard of Conduct	Orientation/ Training & Competency	Current License or Certification	Performance Evaluation	Background Check	Hepatitis B	TB	Comments
Medical Director												
Physicians												
Nurse Practitioners												
Physician Assistants												
Registered Nurses												
Licensed Nurses												
Medical Assistants												
Radiology Technologists												
Receptionist												
Other Clinic Staff												

Notes: Give extent of missing element. (Example 1 of 10)

The Compliance Team®

HR 2.0

HR 2.0 - The organization has written job descriptions for all staff.

Evidence of Compliance

1) The organization has written job descriptions (or checklists) outlining all staff members' responsibilities and accountabilities.
2) Evidence exists that staff members' job descriptions are signed, dated, and placed in their personnel file.

HR 3.0

HR 3.0 - The organization maintains personnel files on all employees and independent contractors.

Evidence of Compliance

1) The organization's confidential personnel files contain the following:

   a. W-4, I-9 for employees;
   b. Curriculum Vitae, Application or Resume with references;
   c. Signed Job Description or contractual agreement;
   d. Orientation/Training /Competency Assessment checklists;
   e. Signed Standards of Conduct;
   f. Copy and validation of current (and past) professional license, registration and/or certification, as applicable;

HR 3.0 Continued:

HR 3.0 - The organization maintains personnel files on all employees and independent contractors.

g. OIG exclusion list verification;

h. Annual performance evaluations;

i. Background checks (when required by the State or organizational policy);

j. Hepatitis B vaccine record or declination. These items are maintained in a separate and secure employee health file;

k. TB evaluation requirements (for staff members with patient contact, specific to the job description). These items are maintained in a separate and secure employee health file; and

l. Copy of current Basic Life Support certification for all licensed personnel providing patient care. This includes a higher-level certification (e.g., ACLS, PALS) when required by organizational policy.

RSK 1.0

RSK 1.0 - The organization has a written process for receiving, reviewing, and preventing patient incidents.

Evidence of Compliance

1) The organization has evidence that incidents are documented on a specific form. The organization can provide a copy of this form upon request.

2) There is a designated staff member responsible for reviewing all incidents and a process in place for taking corrective action and following-up. If the incident results in hospitalization or death, it is reported to TCT within 48 hours.

3) Evidence exists that employees have been trained and are knowledgeable of the process.

The Compliance Team™

RSK 2.0

RSK 2.0 - The organization has a written process for handling employee injuries or exposures.

Evidence of Compliance

1) The organization has evidence that employee incidents, injuries or exposures are documented on a specific form.
2) There is a designated staff member responsible for reviewing all incidents and a process in place for taking corrective action and following-up. If the incident results in hospitalization or death, it is reported to TCT within 48 hours.
3) Employee incidents, injuries or exposure are documented on an incident form.
4) Evidence exists that employees have been trained and are knowledgeable of the process.

Specialty Quality Standards

Equipment Management

Infection Control

Patient Services

Diagnostic Services

Regulatory

The Compliance Team

EQP 1.0

EQP 1.0 - The organization follows written policies and procedures for equipment management.

Evidence of Compliance

1) The organization's equipment management policies and procedures clearly state the process for cleaning, maintaining and storing all equipment. Policies include the following requirements:

    a. All equipment, including equipment loaned to patients (e.g., crutches, wheelchairs or walkers), is cleaned with a healthcare disinfectant according to manufacturer's directions and kept sanitary prior to each patient's use.

    b. Equipment/supplies are stored on shelves, in cabinets and off the floor.

    c. Defective and obsolete equipment is appropriately labeled.

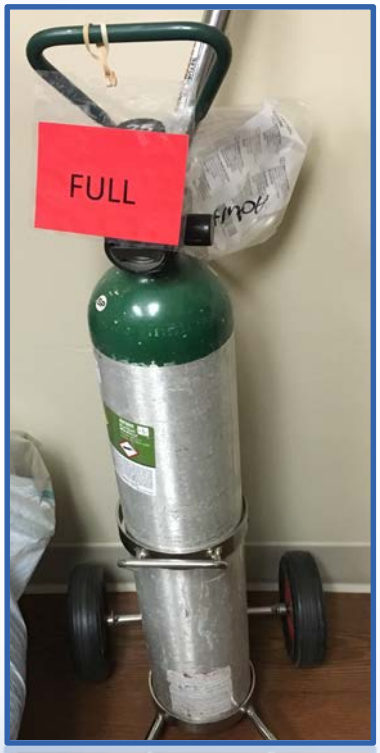
EQP 1.0 Continued:

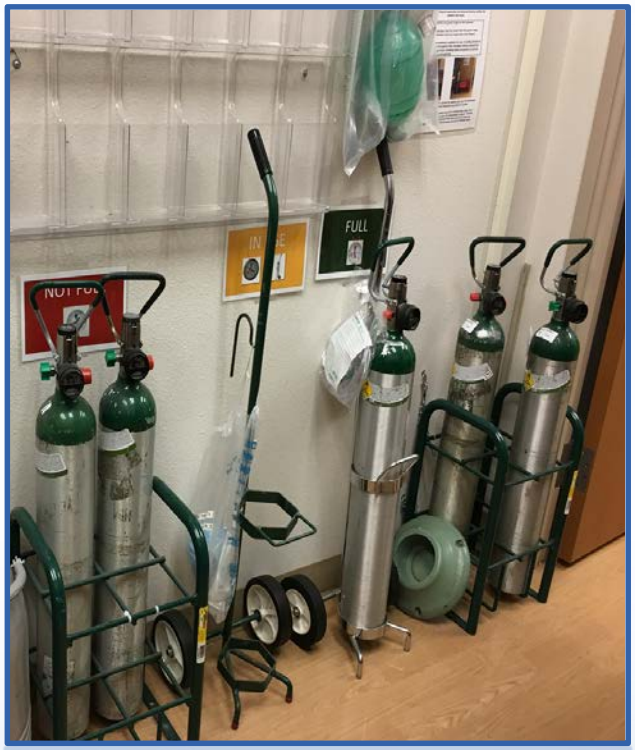
EQP 1.0 - The organization follows written policies and procedures for equipment management.

2) The organization's equipment management policies and procedures address specialty compliance concerning the storage of oxygen tank as applicable:
    a. All oxygen tanks are properly secured and maintained in a well-ventilated area.
    b. If multiple oxygen tanks are maintained, full tanks are stored separately from those that are empty or partially full.

3) The organization has written policies and procedures describing a preventive maintenance program to ensure that:
    a. All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition.
        i. Equipment is inspected/tested according to manufacturer's guidelines and assessed prior to patient use to ensure it is in working order.
        ii. Evidence exists of all preventive maintenance or repairs.
        iii. There is a written process in place for handling equipment/product hazards defects or recalls.

Oxygen Storage in the Clinic





The Compliance Team

INF 1.0

INF 1.0 - The organization follows infection prevention techniques that relate to the type of patient served, services provided and the staff's risk for exposure.

1) The organization has a written infection control policy and procedure reviewed annually.
2) The organization practices infection prevention techniques by utilizing the following:
    a. Hand washing or use of alcohol-based gel before and after each patient contact.
    b. Utilization of gloves while handling or cleaning dirty equipment.
    c. Proper disposal of gloves, sharps and other waste throughout the practice including red bag use.
    d. Standard Precautions when at risk for exposure to blood-borne pathogens.
    e. Prevents cross-contamination by segregating clean from dirty in utility and or storage areas.
3) All sterilization equipment and procedures follow manufacturer guidelines for use.
    a. All instruments are cleaned and sterilized according to the manufacturer's instructions for use.
    b. All sterile packaging has an identifiable expiration due date (if required by manufacturer guidelines).
4) The organization's personnel receive education and training on infection control annually.

Infection Prevention Techniques

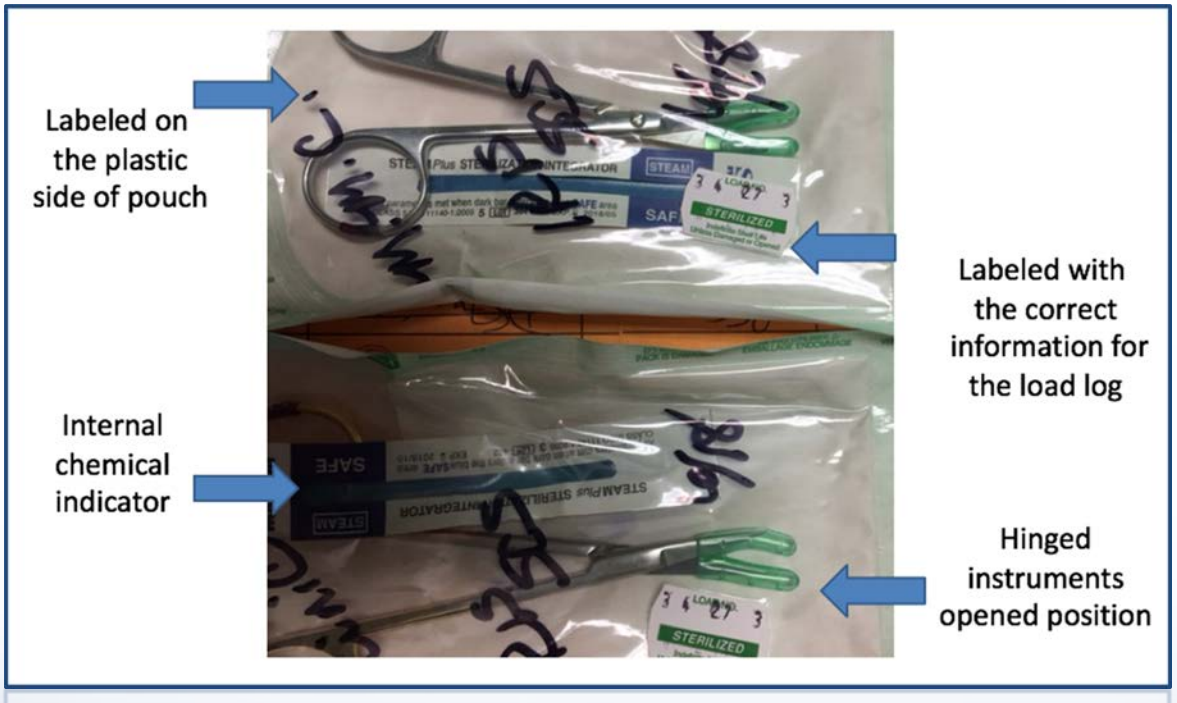
“Clean to Dirty” Process to Avoid Cross-Contamination

Clean Area (Meds)

Dirty Area (Labs)

The Compliance Team™

Sterilization Procedures



The Compliance Team

PTS 1.0

PTS 1.0 - The organization has a process to protect the patient's rights and responsibilities.

Evidence of Compliance

1) The organization has a written patient rights and responsibilities document which is posted and available to patients upon request.
2) Evidence exists that staff has been trained and are knowledgeable on the patient rights and responsibilities document.

PTS 2.0

PTS 2.0 - The organization provides written information to all patients, or when appropriate, the patient's representative, as allowed by State law, upon admission to services.

Evidence of Compliance

1) The organization has a process that information given to patients (or when appropriate, the patient's representative as allowed by State law) contains individual rights under State law to make decisions concerning medical care which includes:
    a. Attaining written consent to treat.
    b. Accepting or refusing care.
    c. Determining the relationship of an authorized representative for all minors and adult patients not capable of giving their consent.

The Compliance Team

DRG 1.0

DRG 1.0 - The organization has written policies and procedures for the storage, handling, and dispensing of drugs and biologicals.

Evidence of Compliance

1) The organization's written policies and procedures include:

   a. Requirements that drugs are stored in original manufacturer's containers to maintain proper labeling.

   b. Requirements that multiple dose vials and single dose vials are stored according to manufacturer guidelines.

   c. Requirements that drugs and biologicals dispensed to patients have complete and legible labeling of containers;

   d. Requirements for a process to regularly monitor the inventory of the organization's drugs, biologicals, and supplies for expiration by the manufacturer's date, beyond-use-dating, or evidence of recall.

   e. Requirements for a process to handle outdated, deteriorated, or adulterated drugs, biologicals, and supplies. These are stored separately and the disposal is in compliance with applicable State laws.

DRG 1.0 Continued:

DRG 1.0 - The organization has written policies and procedures for the storage, handling, and dispensing of drugs and biologicals.

f. Requirements for storage in a space that provides proper humidity, temperature, and light to maintain quality of drugs and biologicals that includes the following:

   i. Refrigerated or frozen medication or vaccines are monitored for storage temperature at least twice daily.
   ii. Temperatures are recorded in a log and staff reports variances in normal findings to organizational leadership.
   iii. No drugs or biologicals are stored in the door of the refrigerator or freezer.
   iv. Water bottles are placed in the door of the medication refrigerator to promote temperature stability.

g. Requirements that current drugs references, antidote information, and manufacturer's guidelines are available on the premises.

DRG 1.0 Continued:

DRG 1.0 - The organization has written policies and procedures for the storage, handling, and dispensing of drugs and biologicals.

h. All controlled substances are handled, as directed by the Drug Enforcement Agency (DEA) Practitioner's Manual, in a manner that guards against theft and diversion.

   i. Schedule II drugs are stored in a securely constructed locked compartment, separate from other drugs.

   ii. Schedule III, IV, and V drugs are secured in a substantially constructed cabinet.

   iii. The organization maintains adequate record keeping of the receipt of controlled drugs and a reconcilable log of the distribution. Should Schedule II drugs be administered in the organization, these drugs are accounted for separately. Any thefts or significant losses are reported to the DEA.

i. Requirements that containers used to dispense drugs and biologicals to patients conform to the Poison Prevention Packaging Act of 1970;

j. Requirements that all prescribing and dispensing of drugs shall be in compliance with applicable State laws.

k. Drugs, Biologicals, and Supplies are appropriately stored.

   i. All sharps, chemicals and electrical hazards are secured.

   ii. A written process is followed to monitor drugs and supplies that are past the manufacturer's expiration date or the beyond-use-date that is assigned when opened

DGS 1.0

DRG 1.0 - The organization provides basic laboratory services essential to immediate diagnosis and treatment as applicable.

Evidence of Compliance

1) The organization has an appropriate CLIA.
2) Evidence exists that all staff performing lab services have been trained and their competency validated upon-hire and annually.

REG 1.0

REG 1.0 - The organization is in compliance with applicable local, State, and Federal laws or regulations.

Evidence of Compliance

1) The organization is licensed in accordance with applicable State and local laws.
2) The organization displays all licenses, certificates and permits to operate, as required.

REG 2.A

REG 2.A - The organization is in compliance with the OSHA Blood-Borne Pathogen Standard as it relates to the type of patient served, services provided, and staff's risk for exposure.

Evidence of Compliance

1) The organization has a written work-exposure plan that determines the job classifications of staff at risk of blood-borne pathogen exposure and the work-practice controls and personal protective equipment (PPE) that are made available to protect them. The plan is reviewed and/or updated at least annually.

2) All PPE is provided by the employer and is readily accessible to staff.

3) If identified as being at risk for exposure to blood-borne pathogens, the staff member is offered full Hepatitis B vaccination series at the employer's expense. If declined, a signed declination form appears in the personnel file.

4) Evidence exists that all staff have received training on the OSHA Bloodborne Pathogens Standard upon-hire and annually.

Thinking Beyond the Usual: PPE for Liquid Nitrogen Tank Refills

The Compliance Team™

REG 2.B

REG 2.B - The organization is in compliance with current OSHA and CDC guidelines for preventing the transmission of Mycobacterium Tuberculosis in health care settings.

Evidence of Compliance

1) The organization conducts an initial and on-going risk assessment for TB transmission by occupational exposure. Factors to be considered may include: risk by geographical location as determined by the State Department of Health, the type of patient population served (including fluctuations of population caused by temporary workers or tourism), and the reported cases of TB in the organization in the past year.

2) Based upon assessment of risk, the organization follows current OSHA and CDC guidelines to determine the types of administrative, environmental, respiratory protection controls, and medical surveillance needed.

3) There is evidence the organization conducts TB screening upon hire.

4) Evidence exists that all staff have received TB transmission prevention training upon-hire and annually.

REG 2.C

REG 2.C - The organization is in compliance with OSHA's Right to Know Standard.

Evidence of Compliance

1) Safety Data Sheets (SDS) are available for all hazardous material in the organization's workplace and employees are knowledgeable of the location of the references.
2) The organization posts all mandatory OSHA posters for all employees to view.
3) Evidence exists that staff is trained on identifying hazards in the workplace.

REG 2.D

REG 2.D - The organization has an emergency preparedness plan that addresses an emergency on-site, off-site (natural disaster) and disruption of service.

1) The organization has a written emergency preparedness plan with an organized process for handling an on-site emergency, (e.g., fire, active shooter) addressing the following:

   a. How employees will be notified of emergency;
   b. Which staff member is responsible for calling 911;
   c. The location where employees should meet outside the building; and
   d. The staff person designated to do head count upon evacuation of the building

2) Fire Safety requirements are met as follows:

   a. Fire extinguisher is mounted and has been checked and approved for use.
   b. Upon on hire and annual in-service for all employees on Fire Safety (including how to operate an extinguisher).

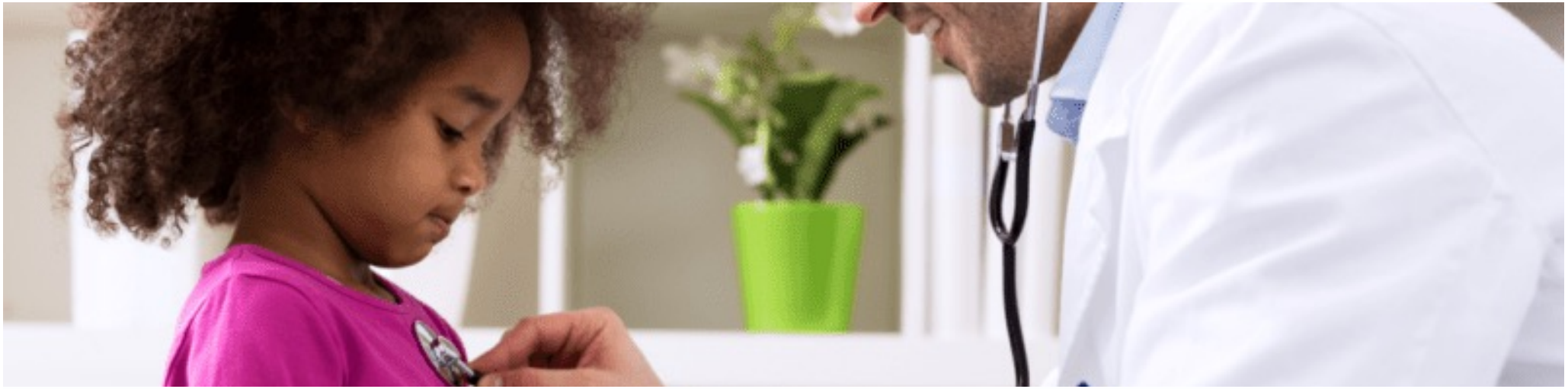
REG 2.D Continued:

REG 2.D - The organization has an emergency preparedness plan that addresses an emergency on-site, off-site (natural disaster) and disruption of service.

3) The organization has a written emergency preparedness plan with an organized process for handling an off-site emergency, (e.g. snowstorm, flood, etc.) addressing the following:

   a. How employees will be notified of emergency;
   b. Which staff member is responsible for notification of patients;
   c. How refrigerated medications are handled during a power outage; and
   d. How it will implement a contingency plan, that includes routing patients to an alternative provider in the event the organization cannot see its own patients for an extended period of time.

4) Evidence exists of annual emergency preparedness staff training in personnel files or training records.



April 2021

Implementing the PCMH Model

Patient Centered Medical Home: A Practice Model to Improve Quality

Session 3, Part Three

The Compliance Team®

Where to Begin?

✓ **Review of standards – We just completed step one!**

Review PCMH Checklist and check off what you are already doing.

Identify the gaps and highlight what areas need attention.

Review Policy section of checklist and see what policies you may not have in place.

Refer to TCT policy templates and other resources. What can you use from the available resources to save valuable time?

What are you doing now to capture quality measures and patient satisfaction surveys?

What is the process for each role in the clinic? Let's get each person functioning at the top of their ability!

What is done well?

What can be improved on?

**Answer these key questions and develop a prep/implementation plan.

The Compliance Team®

Preparation and Implementation

Remember this is a team project but you need a provider champion.

Look at workflow

Educate all providers and staff on quality performance measures

Use Huddles to scrub the schedule for issues, delegate what you can

Involve your pharmacists, Remember 50% of all prescriptions will either not be used at all or used improperly. One study shows that people who received MTM services from a pharmacist were three times more likely to remain out of the hospital after 60 days.

Electronic benchmarking:

How do you improve when you are already providing quality care? Ask your patients!

Make a Convincing Argument: Be a Champion for Change!

Quite often, it's easier to complain about what isn't working for one instead of finding innovative solutions to make workflow better for all.

Some common complaints are:

"There's not enough hours in the day and now you want to add this to my plate?"

"I'm already stressed out and no one seems to listen or care"

"I don't think things will ever change, that's' frustrating!"

The catalyst for change is being able to make a convincing argument that to expect improvement, one must be willing to embrace a new approach to traditional methods.

Once providers and staff agree that transitioning to the PCMH model can improve workflow and quality of life for providers, staff and patients alike, then you have set the stage for a successful medical home.

The Compliance Team

Implementing the PCMH Model

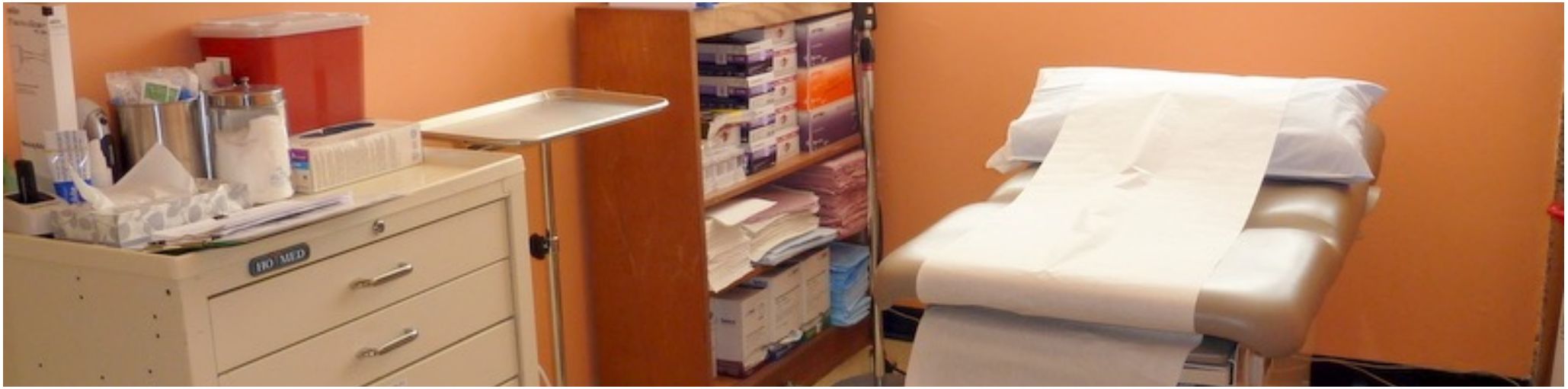
Remember:

It's a journey, not a destination! Quality Improvement over time that benefits all.

Huddles and Hurdles…there will be both but the team that huddles together can overcome any hurdles if the goal is improvement not transformation.

"What Matters Most" – Patient Satisfaction AND Staff Satisfaction, they go hand in hand.

The **primary care team** is **essential** to providing comprehensive care. By focusing on patient health goals for a healthier lifestyle, preventative care and coordinated management of chronic disease for longevity and quality of life, this whole patient perspective is the **heart of a Patient Centered Medical Home**.



April 2021

Conducting a Mock Survey

Patient Centered Medical Home: A Practice Model to Improve Quality

Session 3, Part Three

The Compliance Team®

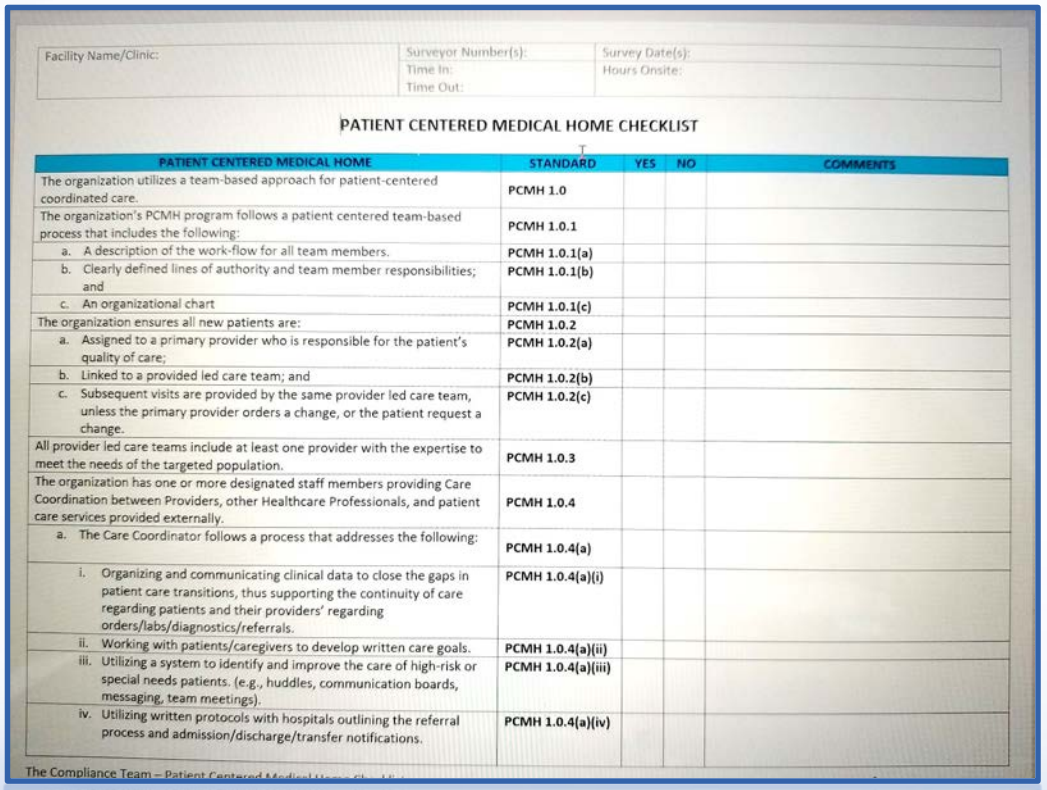
PCMH – Session 3, Handout 1 and 2

Refer to Session 3, Handout 1 and 2

Survey Checklist

Mock Survey Instructions

The PCMH Checklist



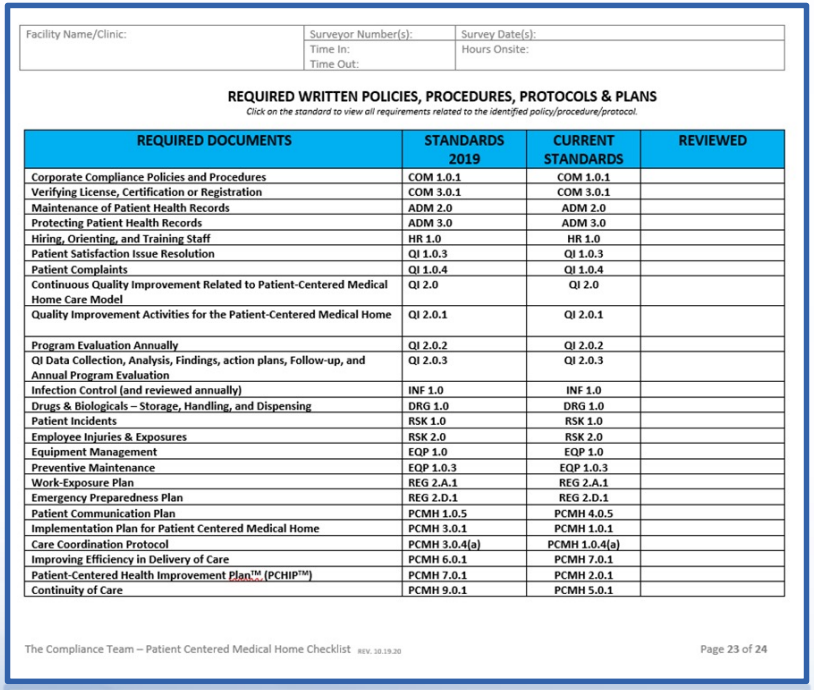
Facility Name/Clinic:	Surveyor Number(s): Time In: Time Out:	Survey Date(s): Hours Onsite:

PATIENT CENTERED MEDICAL HOME CHECKLIST

PATIENT CENTERED MEDICAL HOME	STANDARD	YES	NO	COMMENTS
The organization utilizes a team-based approach for patient-centered coordinated care.	PCMH 1.0			
The organization's PCMH program follows a patient centered team-based process that includes the following:	PCMH 1.0.1			
a. A description of the work-flow for all team members.	PCMH 1.0.1(a)			
b. Clearly defined lines of authority and team member responsibilities; and	PCMH 1.0.1(b)			
c. An organizational chart	PCMH 1.0.1(c)			
The organization ensures all new patients are:	PCMH 1.0.2			
a. Assigned to a primary provider who is responsible for the patient's quality of care;	PCMH 1.0.2(a)			
b. Linked to a provided led care team; and	PCMH 1.0.2(b)			
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.	PCMH 1.0.2(c)			
All provider led care teams include at least one provider with the expertise to meet the needs of the targeted population.	PCMH 1.0.3			
The organization has one or more designated staff members providing Care Coordination between Providers, other Healthcare Professionals, and patient care services provided externally.	PCMH 1.0.4			
a. The Care Coordinator follows a process that addresses the following:	PCMH 1.0.4(a)			
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.	PCMH 1.0.4(a)(i)			
ii. Working with patients/caregivers to develop written care goals.	PCMH 1.0.4(a)(ii)			
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).	PCMH 1.0.4(a)(iii)			
iv. Utilizing written protocols with hospitals outlining the referral process and admission/discharge/transfer notifications.	PCMH 1.0.4(a)(iv)			

The Compliance Team™

Working the Checklist – Policy Review



Facility Name/Clinic:	Surveyor Number(s): Time In: Time Out:	Survey Date(s): Hours Onsite:

REQUIRED WRITTEN POLICIES, PROCEDURES, PROTOCOLS & PLANS

Click on the standard to view all requirements related to the identified policy/procedure/protocol.

REQUIRED DOCUMENTS	STANDARDS 2019	CURRENT STANDARDS	REVIEWED
Corporate Compliance Policies and Procedures	COM 1.0.1	COM 1.0.1	
Verifying License, Certification or Registration	COM 3.0.1	COM 3.0.1	
Maintenance of Patient Health Records	ADM 2.0	ADM 2.0	
Protecting Patient Health Records	ADM 3.0	ADM 3.0	
Hiring, Orienting, and Training Staff	HR 1.0	HR 1.0	
Patient Satisfaction Issue Resolution	QI 1.0.3	QI 1.0.3	
Patient Complaints	QI 1.0.4	QI 1.0.4	
Continuous Quality Improvement Related to Patient-Centered Medical Home Care Model	QI 2.0	QI 2.0	
Quality Improvement Activities for the Patient-Centered Medical Home	QI 2.0.1	QI 2.0.1	
Program Evaluation Annually	QI 2.0.2	QI 2.0.2	
QI Data Collection, Analysis, Findings, action plans, Follow-up, and Annual Program Evaluation	QI 2.0.3	QI 2.0.3	
Infection Control (and reviewed annually)	INF 1.0	INF 1.0	
Drugs & Biologicals – Storage, Handling, and Dispensing	DRG 1.0	DRG 1.0	
Patient Incidents	RSK 1.0	RSK 1.0	
Employee Injuries & Exposures	RSK 2.0	RSK 2.0	
Equipment Management	EQP 1.0	EQP 1.0	
Preventive Maintenance	EQP 1.0.3	EQP 1.0.3	
Work-Exposure Plan	REG 2.A.1	REG 2.A.1	
Emergency Preparedness Plan	REG 2.D.1	REG 2.D.1	
Patient Communication Plan	PCMH 1.0.5	PCMH 4.0.5	
Implementation Plan for Patient Centered Medical Home	PCMH 3.0.1	PCMH 1.0.1	
Care Coordination Protocol	PCMH 3.0.4(a)	PCMH 1.0.4(a)	
Improving Efficiency in Delivery of Care	PCMH 6.0.1	PCMH 7.0.1	
Patient-Centered Health Improvement Plan™ (PCHIP™)	PCMH 7.0.1	PCMH 2.0.1	
Continuity of Care	PCMH 9.0.1	PCMH 5.0.1	

Complete a policy review prior to the mock survey to determine if policies are being followed and protocols adhered to by staff. Staff should be knowledgeable regarding areas they are responsible for and be able to answer questions regarding clinic policy that pertains to specific duties and standards of conduct.

The Compliance Team™

Working the Checklist – Clinic Walkthrough

How to conduct a PCMH Self-Mock Survey

1) Conduct a self-mock survey using TCT's PCMH Checklist by reviewing each item listed and recording your answer.

2) Mark each item as compliant (Yes) or noncompliant (No). If the clinic is noncompliant, write notes in the comment section of the checklist documenting why the clinic is not compliant with the standard for discussion with your staff once the self-survey is final.

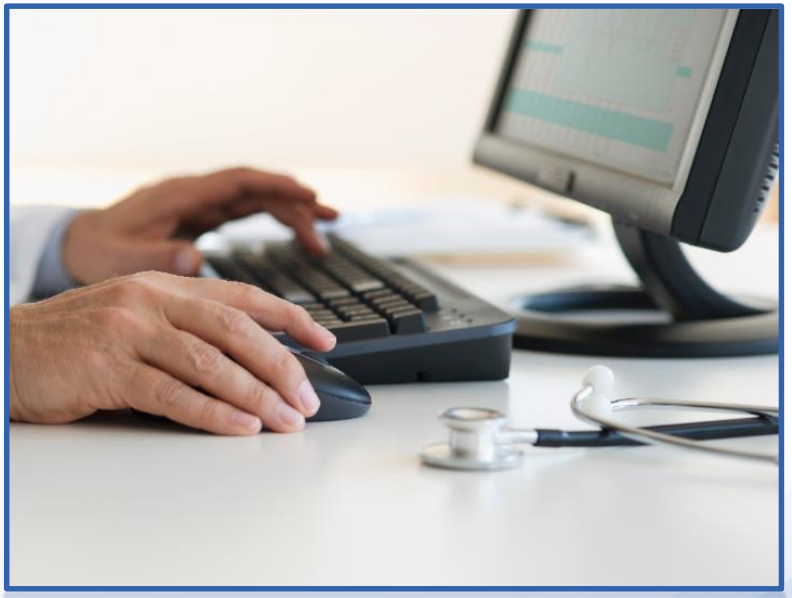
The Compliance Team

Working the Checklist – HR Audit

3) Fill out Licensed Personnel Audit Form for all licensed, registered, and/or certified personnel and HR Audit Form for all personnel.

   a. The person responsible for HR should conduct the audit of all personnel records to ensure privacy of protected employee information.

   b. If the individual field does not apply to that staff member, simply insert N/A. For example, if the staff member has been employed less than one year, N/A is an appropriate entry for the performance evaluation. In the comment section-explain each N/A entry. If elements are missing once the audits are complete, make sure you discuss with HR to ensure all files are complete prior to onsite survey.



The Compliance Team

Working the Checklist – Medical Record Audit

4) Randomly select 10 PCMH patient health records that have been seen in the clinic in the past 2-3 weeks and conduct an audit marking each entry as Y or N or N/A if there were no labs ordered that day. The sample must include at least two patients that had a lab order and at least four over 65 years of age. Please do not include Telehealth patients. As you complete the patient healthcare record review, use the following unique identifier that protects PHI and consists of the following:

The Compliance Team

Working the Checklist – Medical Record Audit Continued:

a. Each patient health record reviewed will be assigned a unique identifier that consists of the following:

   i. A numerical number that identifies the record reviewed. For example, when the surveyor reviews the first record, it will be noted as number 1. The review of the second record will include the number 2, etc.;

   ii. A key that contains the first two initials of the last name, the date of service, followed by the first initial of the patient's first name; and

   iii. The date of service will be identified as a numerical number with a 2-digit month, the actual date of service and a 2-digit year. For instance, if the patient is seen in the clinic on February 1, 2018, the numerical identifier for the date of service would be 020118.

   iv. Using the method listed above, an example of a unique identifier for the first record reviewed of a patient named John Doe, seen in the clinic on February 1, 2018 would be: 1Do020118J. If the patient is a minor, identify with the letter M at the end of the sequence 1Do020118JM

Addressing Any Areas of Non-Compliance with Staff

4) Review all items on the PCMH checklist marked NO and address those items with your team. This is an open book test using the same checklist the surveyor will use so you should be able to answer Yes to all items on the checklist.

5) Once the PCMH self-mock survey is complete and all items answered Yes, you are ready for a TCT onsite survey.

The Compliance Team™

All Yes? You Are Ready for Onsite Survey

Onsite Agenda

Following is an overview of the day our surveyors will spend reviewing the clinic during your evaluation.

- Meeting with the management staff and providers, as many as are available.
- Interviews with care coordinator conducted throughout the day
- Review EHR records through HIPAA protected system
- Wrap up meeting and exit conference.

Onsite Survey Agenda Continued - Documents

Please have the following available:

- PCMH Policy and procedure manuals and forms.
- Patient medical record review - 10 random files.
- Copy of an up-to-date organization chart.
- HR files of all personnel
- Quality improvement meeting minutes (if applicable).
- List of patient files which have been reviewed for quality improvement.
- Evidence of employee PCMH training.

Important Reminder!

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

The Compliance Team

Facilitator Perspective

A Discussion with a PCMH Facilitator

April 2021

The Compliance Team®

A Facilitator Perspective

"We know successful PCMH Implementation demonstrates a positive quality of care perspective not just to your patients but to your community."

The Compliance Team

Let's Do A Quick Quality Review

- Do you have a framework?
  - PDSA
  - Lean
  - Other
- How do you identify opportunity?
- Or jump right in ☺

Data is Your Friend

- What data aspects can you identify quickly?
- Where does your data come from?
  - Claims data
  - Hospital vs clinic data
  - Patient/staff/provider feedback

“But Where Do I Start?”

- **Ask your staff: “the Challenge”**
  - Sticky note activity – Sort – Set – Select
  - Common complaints
  - Types of visits
  - Types of phone calls
- Huddles are best source of what is missing
- Assemble the team!
  - Champion
  - Start small
- Share your progress!!!

The Compliance Team®

Quality Data Ideas

- Readmissions (yes in collaboration with hospital)
- Disease Management
  - HTN
  - Diabetes
  - CHF
  - Asthma
  - BMI

- Health literacy
- Medication management/reconciliation
- Immunizations
- MWV
- Health screenings
- Patient compliance/adherence to treatment

ED Utilization

- **Hospital:**
  - How to run a report of frequent ED visits
  - Who runs report? How often run report?
  - Do you have an ED Frequent Utilizer list?
  - Any education provided to patients while in ED?
  - Evaluation of PCP? Specialist?
  - Discharge Instructions

ED Utilization - Continued

- **Clinic:**
  - How many of current patients use the ED as PCP?
  - What disease registries are patients associated with
  - What information/education provided?
  - Being seen routinely by PCP?
  - Current access to care? Open appointments?
  - Community resources to assist?

Outcome

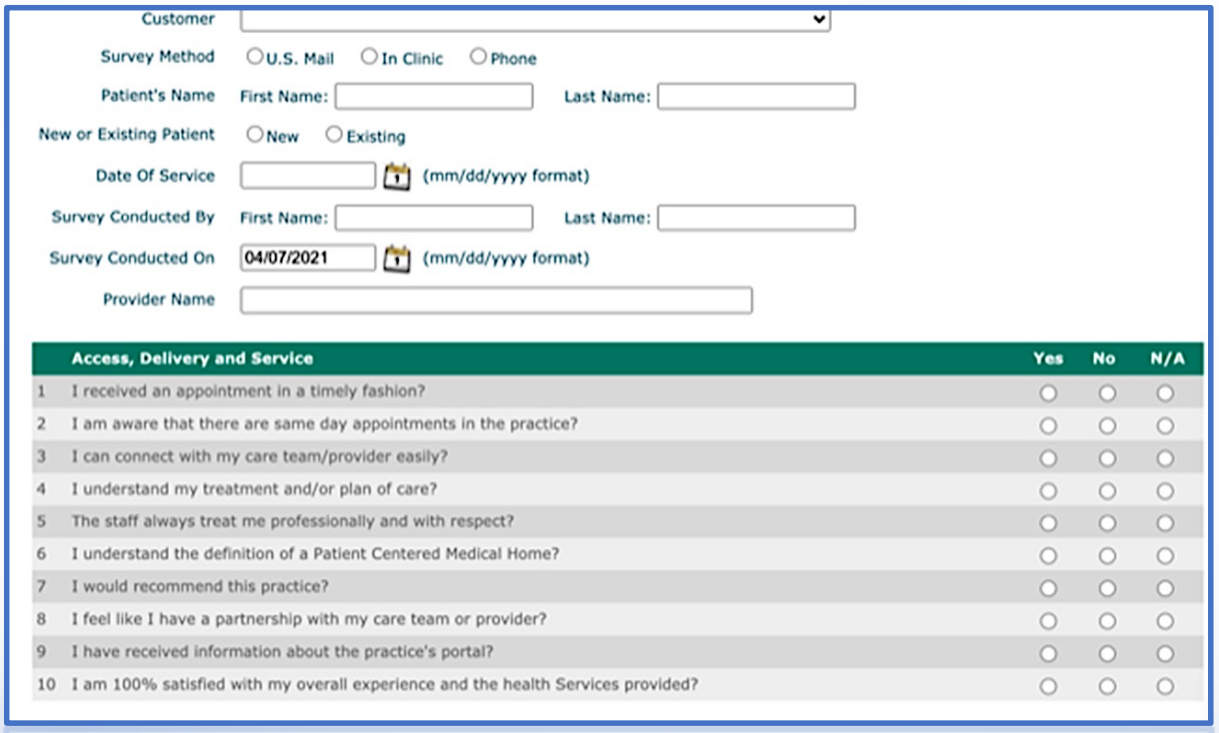
- Carthage Memorial Hospital
- Identified 55 frequent ED users
- Established connection with all 55
- Ongoing communication, office visits, self-management skill training of disease(s)
- Monitored from January to March
- In April only one had return visit to ED!

The Compliance Team

TCM or Post DC Management

- Enhance patient engagement/experience
- Reduction in readmissions
- Action
  - Identify discharge patients
  - Call within 48 hours of discharge
  - Answer any questions
  - Identify medication reconciliation
  - Confirm follow up visit with PCP
  - Establish any self-management needs
  - Reduction of potential exacerbation of disease process

The Patient Experience



Customer

Survey Method ○U.S. Mail ○In Clinic ○Phone

Patient's Name First Name: Last Name:

New or Existing Patient ○New ○Existing

Date Of Service (mm/dd/yyyy format)

Survey Conducted By First Name: Last Name:

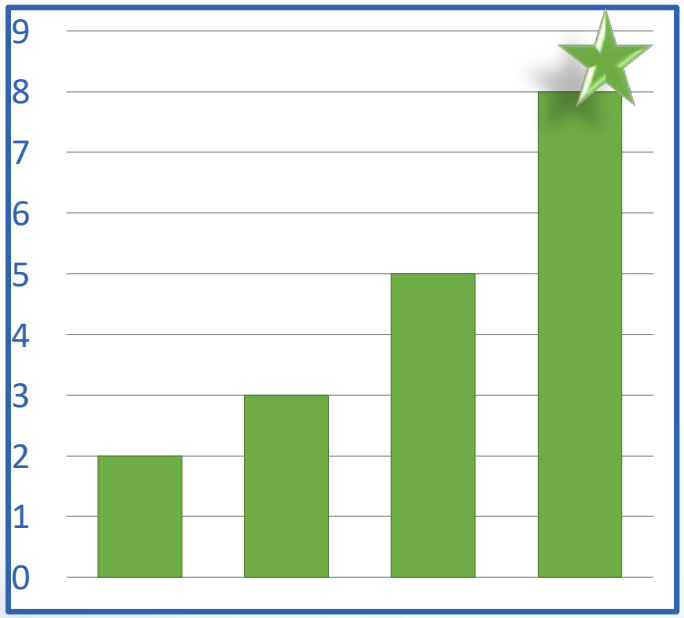
Survey Conducted On 04/07/2021 (mm/dd/yyyy format)

Provider Name

	Access, Delivery and Service	Yes	No	N/A
1	I received an appointment in a timely fashion?	○	○	○
2	I am aware that there are same day appointments in the practice?	○	○	○
3	I can connect with my care team/provider easily?	○	○	○
4	I understand my treatment and/or plan of care?	○	○	○
5	The staff always treat me professionally and with respect?	○	○	○
6	I understand the definition of a Patient Centered Medical Home?	○	○	○
7	I would recommend this practice?	○	○	○
8	I feel like I have a partnership with my care team or provider?	○	○	○
9	I have received information about the practice's portal?	○	○	○
10	I am 100% satisfied with my overall experience and the health Services provided?	○	○	○

Patient Experience Benchmarking

Improvement at point of care



The Compliance Team

Improving Quality Through Measurement

1. • Calling patients vs Mailing
2. • Focus questions on what matters to patients
3. • Sends POWERFUL message to patients that you care

The Compliance Team

Other Measures

- **Care Coordination/Patient Safety**
  - Med Rec
  - Falls screening for future fall risk
  - Imaging studies for back pain
- **Preventative measures**
  - Influenza/COVID
  - Pneumonia/Shingles
  - Colorectal/Breast CA screens
  - Depression screening

Clinical Care Measures

- Hgb A1C Managed (not poor control)
- HTN medications reduced/managed
- Diabetes
  - Eye exam
  - Foot exam
- Consider provider measure

Winning at Quality

- Engage ALL staff
- Make it fun!
  - Smoothie Day/Ice Cream Day
  - Challenge between teams
  - Chair massage day
  - Employee pick for music of the day
- Post patient testimonials!
- Get Creative! Innovative!

The Compliance Team®

Successful Survey

- Review standards as a team!
- Quiz questions at huddles to test knowledge
- Use all the tools provided to prepare
- Engage – Educate – Excite staff
- Readiness Binder… show off your hard work!
- Frequent walk throughs (use other eyes)

Happy Endings…

Patient /Case Example

- 64-year-old Homeless White Female
- COPD, Diabetes, Oxygen Dependent
- No Health Insurance
- Averages Two ER Admissions per Week and Twenty Hospital Admissions over a two-year period
- Cost to the Hospital: $760,000 per year

Hospital Found and Paid for Low Income Housing

Social Worker Enrolled Patient in Medicaid

Hospital Introduced Patient to a Primary Care Physician in Patient Centered Medical Home

Within 6 Months, Utilizing Clinical Guidelines, Chronic Diseases were well controlled

Over the next 2 years, patient had one hospitalization per year and no ER visits

Total Cost to the Hospital System over the next two years: $32,000 per year

You can have an even greater impact on improving the quality of your patient's lives!

Communities across the country including many in Missouri need more Patient Centered Medical Homes.

Leading edge patient centered care begins when you see yourself playing a part in the Happy Endings!

The Compliance Team

Thank You For All You Do!

The Compliance Team™

A Big Thank You to MO Dept of Health and HRSA for Funding

The Compliance Team

Thank you for attending the PCMH Training Webinars!

QUESTIONS?

Kate Hill, RN,
VP Clinic Division
215-654-9110
khill@thecomplianceteam.org

Theresa Griffin-Rossi,
Program Dev. Advisor PCMH
215-654-9110
tgriffinrossi@thecomplianceteam.org

The Compliance Team

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

PATIENT CENTERED MEDICAL HOME CHECKLIST

PATIENT CENTERED MEDICAL HOME	STANDARD	YES	NO	COMMENTS
The organization utilizes a team-based approach for patient-centered coordinated care.	**PCMH 1.0**			
The organization's PCMH program follows a patient centered team-based process that includes the following:	**PCMH 1.0.1**			
a. A description of the work-flow for all team members.	**PCMH 1.0.1(a)**			
b. Clearly defined lines of authority and team member responsibilities; and	**PCMH 1.0.1(b)**			
c. An organizational chart	**PCMH 1.0.1(c)**			
The organization ensures all new patients are:	**PCMH 1.0.2**			
a. Assigned to a primary provider who is responsible for the patient's quality of care;	**PCMH 1.0.2(a)**			
b. Linked to a provided led care team; and	**PCMH 1.0.2(b)**			
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.	**PCMH 1.0.2(c)**			
All provider led care teams include at least one provider with the expertise to meet the needs of the targeted population.	**PCMH 1.0.3**			
The organization has one or more designated staff members providing Care Coordination between Providers, other Healthcare Professionals, and patient care services provided externally.	**PCMH 1.0.4**			
a. The Care Coordinator follows a process that addresses the following:	**PCMH 1.0.4(a)**			
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.	**PCMH 1.0.4(a)(i)**			
ii. Working with patients/caregivers to develop written care goals.	**PCMH 1.0.4(a)(ii)**			
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).	**PCMH 1.0.4(a)(iii)**			
iv. Utilizing written protocols with hospitals outlining the referral process and admission/discharge/transfer notifications.	**PCMH 1.0.4(a)(iv)**			

v. Providing a summary for patients transferring to another medical provider.	**PCMH 1.0.4(a)(v)**			
vi. Providing support to patients/caregivers by helping them connect to community resources.	**PCMH 1.0.4(a)(vi)**			
vii. Transition Care Management Services (as applicable).	**PCMH 1.0.4(a)(vii)**			
The Care Coordinator monitors care provided to patients by other providers including:	**PCMH 1.0.5**			
a. Specialists managing patient medications, ordering labs, diagnostics, treatments, procedures, and/or therapies.	**PCMH 1.0.5(a)**			
b. Pharmacists regarding patient medication history, adherence, and any involvement with medication therapy management.	**PCMH 1.0.5(b)**			
The organization utilizes a Patient Center Health Improvement Plan ™ (PCHIP™) for those patients whose care needs to be managed and coordinated.	**PCMH 2.0**			
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	**PCMH 2.0.1**			
a. Identify high risk and/or complex patients in the practice.	**PCMH 2.0.1(a)**			
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:	**PCMH 2.0.1(b)**			
i. When a physical or mental impairment or learning disability exists;	**PCMH 2.0.1(b)(i)**			
ii. When English is not the primary language spoken; or	**PCMH 2.0.1(b)(ii)**			
iii. When cultural or religious beliefs may impact the delivery of care.	**PCMH 2.0.1(b)(iii)**			
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.	**PCMH 2.0.1(c)**			
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.	**PCMH 2.0.1(d)**			
e. When appropriate, incorporate end-of-life or palliative care planning.	**PCMH 2.0.1(e)**			

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

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:	**PCMH 2.0.2**			
a. The forms of communication and/or resources that allow for meaningful healthcare interactions and education;	**PCMH 2.0.2(a)**			
b. Language and cultural competency;	**PCMH 2.0.2(b)**			
c. Indicators that prompt social support discussions and referrals;	**PCMH 2.0.2(c)**			
d. Short and long-term goal planning; and	**PCMH 2.0.2(d)**			
e. Indicators that prompt end-of-life or palliative care discussions.	**PCMH 2.0.2(e)**			
The organization provides patient education and self-management tools to patients and their family/caregivers.	**PCMH 3.0**			
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.	**PCMH 3.0.1**			
Evidence exists in the patient's healthcare record that the patient and their family/caregivers were provided healthcare education and self-management tools .	**PCMH 3.0.2**			
The organization provides advanced access to its patients	**PCMH 4.0**			
The organization's provides advanced access by expanding hours of operation beyond traditional appointment hours. Increased patient access includes:	**PCMH 4.0.1**			
a. Same day appointments for urgent illness;	**PCMH 4.0.1(a)**			
b. Evidence of expanded weekday, evening, and/or weekend appointment offerings; and	**PCMH 4.0.1(b)**			
c. Call coverage or arrangement for after-hours emergencies twenty-four hours a day and seven days a week.	**PCMH 4.0.1(c)**			
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.	**PCMH 4.0.2**			
The organization communicates essential practice information to its patients. This information includes:	**PCMH 4.0.3**			
a. What patients should bring to each appointment;	**PCMH 4.0.3(a)**			

b. How patient calls and prescription requests are handled;	**PCMH 4.0.3(b)**			
c. The routes in which patients can attain healthcare access after-hours; and	**PCMH 4.0.3(c)**			
d. Policies regarding the rescheduling or cancellation of appointments.	**PCMH 4.0.3(d)**			
Evidence exists of advanced access through multiple forms of communication with its patients.	**PCMH 4.0.4**			
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.	**PCMH 4.0.5**			
Evidence exists that the organization actively engages with community resources to reach out to its patient population.	**PCMH 4.0.6**			
The organization provides patient follow-up.	**PCMH 5.0**			
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:	**PCMH 5.0.1**			
a. Missed patient appointments.	**PCMH 5.0.1(a)**			
b. Requests for medication refills by patients.	**PCMH 5.0.1(b)**			
c. High-risk medication(s) or in-home treatment(s) that are newly prescribed.	**PCMH 5.0.1(c)**			
d. Laboratory or diagnostic results.	**PCMH 5.0.1(d)**			
e. Referrals and consultations.	**PCMH 5.0.1(e)**			
f. Preventative care and screening reminders.	**PCMH 5.0.1(f)**			
g. Care coordination activities.	**PCMH 5.0.1(g)**			
h. Frequent use of the emergency department.	**PCMH 5.0.1(h)**			
i. Discharge from the hospital.	**PCMH 5.0.1(i)**			
Evidence of follow-up communication with patients exists in the patient health record	**PCMH 5.0.2**			
The organization meets the healthcare needs of patients when they are closed.	**PCMH 6.0**			
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.	**PCMH 6.0.1**			

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

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.	**PCMH 6.0.2**			
The organization has a comprehensive process that provides patients the ability to communicate their healthcare needs after-hours.	**PCMH 6.0.3**			
The organization takes steps to reduce unnecessary utilization of services.	**PCMH 7.0**			
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:	**PCMH 7.0.1**			
a. Reducing avoidable patient emergency department (ED) visits;	**PCMH 7.0.1(a)**			
b. Reducing patient hospital re-admissions; and	**PCMH 7.0.1(b)**			
c. Offering same-day appointments.	**PCMH 7.0.1(c)**			
Evidence exists that the organization reports data on the following utilization of services quarterly to The Compliance Team:	**PCMH 7.0.2**			
a. Number of patients requiring care coordination,	**PCMH 7.0.2(a)**			
b. Number of ED visits,	**PCMH 7.0.2(b)**			
c. Number of avoidable ED visits,	**PCMH 7.0.2(c)**			
d. Number of hospital admissions, and	**PCMH 7.0.2(d)**			
e. Number of hospital readmissions.	**PCMH 7.0.2(e)**			
The organization ensures patient health records are complete	**PCMH 8.0**			In no, please see patient health record review below for details.
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:	**PCMH 8.0.2**			
a. Current vital signs;	**PCMH 8.0.2(a)**			
b. Relevant health data;	**PCMH 8.0.2(b)**			
c. Current diagnosis;	**PCMH 8.0.2(c)**			
d. Current medications;	**PCMH 8.0.2(d)**			

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

e. Important patient instructions;	**PCMH 8.0.2(e)**			
f. Patient's short and long-term healthcare goals;	**PCMH 8.0.2(f)**			
g. Name of patient's provider; and	**PCMH 8.0.2(g)**			
h. PCMH contact Information.	**PCMH 8.0.2(h)**			
Evidence exists, in QI Meeting minutes, that the organization:	**PCMH 8.0.3**			
a. Audits patient health records for completeness and accuracy. Audit results meet compliance with the number of records and frequency, as defined by organizational policy;	**PCMH 8.0.3(a)**			
b. Analyzes data and reports findings to leadership; and	**PCMH 8.0.3(b)**			
c. Identifies performance improvement opportunities and takes corrective action.	**PCMH 8.0.3(c)**			
QUALITY IMPROVEMENT PLAN	**STANDARD**	**YES**	**NO**	**COMMENTS**
The organization collects data for patient satisfaction, dissatisfaction, and complaints.	**QI 1.0**			
The organization ensures a sample of patients receive a patient satisfaction survey. The patient sample size is determined by organizational policy.	**QI 1.0.1**			
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.	**QI 1.0.2**			
The organization has a process to develop and implement corrective action if the results of the patient satisfaction evaluation reveal possible issues.	**QI 1.0.3**			
The organization has a written policy and procedure for defining, handling, reviewing and resolving complaints.	**QI 1.0.4**			
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."	**QI 1.0.5**			
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.	**QI 1.0.6**			
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.	**QI 2.0**			

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

The organization has written policies and procedures outlining its Quality Improvement (QI) activities. The policies and procedures include the following:	**QI 2.0.1**			
a. Designating a staff member for oversight of the QI activities.	**QI 2.0.1(a)**			
b. Monitoring the following:	**QI 2.0.1(b)**			
i. Completeness/accuracy of patient health records (random chart audit volume and frequency will be determined by organizational policy);	**QI 2.0.1(b)(i)**			
ii. Compliance with preventive-health measures (as required by Medicaid or third-party payers);	**QI 2.0.1(b)(ii)**			
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 2.0.1(b)(iii)**			
iv. Incident reporting;	**QI 2.0.1(b)(iv)**			
v. Patient satisfaction data;	**QI 2.0.1(b)(v)**			
vi. Number of same day appointments (which addresses increased patient access);	**QI 2.0.1(b)(vi)**			
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.	**QI 2.0.1(b)(vii)**			
viii. Percentage of generic medications prescribed; and	**QI 2.0.1(b)(viii)**			
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.	**QI 2.0.1(b)(ix)**			
x. Number of patients followed-up after discharge from the hospital (as determined by Admission/Discharge/Transfer reporting).	**QI 2.0.1(b)(x)**			
c. Analyzing data and reviewing findings with key leadership at least quarterly.	**QI 2.0.1(c)**			
d. Identifying performance improvement opportunities and taking corrective action when needed.	**QI 2.0.1(d)**			
e. Communicating changes throughout the organization.	**QI 2.0.1(e)**			

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

f. Following-up to ensure the desired change is achieved through the corrective action(s).	**QI 2.0.1(f)**			
Annually, the organization performs a program evaluation to:	**QI 2.0.2**			
a. Review the following	**QI 2.0.2(a)**			
Utilization review of all services provided by the PCMH;	**QI 2.0.2(a)(i)**			
The number of patients served and volume of services;	**QI 2.0.2(a)(ii)**			
Organizational policies and procedures; and	**QI 2.0.2(a)(iii)**			
Trends from the past year's QI data (as defined in QI 2.0.1(b)(i-x)	**QI 2.0.2(a)(iv)**			
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.	**QI 2.0.2(b)**			
Make changes to the PCMH plan as required.	**QI 2.0.2(c)**			
Evidence exists of the QI data collection and analysis, findings, action-plans, follow-up, and the annual PCMH program evaluation	**QI 2.0.3**			

***NOTE: IF YOU ARE A TCT ACCREDITED RURAL HEALTH CLINIC, THE STANDARDS BEYOND THIS POINT DO NOT APPLY. PLEASE PROCEED TO PAGES 18-24 AND COMPLETE THE HR AUDIT, MEDICAL RECORD REVIEW, POLICY REVIEW & PATIENT INTERVIEWS.**

ORGANIZATIONS THAT ARE NOT AN ACCREDITED TCT RURAL HEALTH CLINIC MUST MEET THE ADDITIONAL STANDARDS OUTLINED BELOW

CORPORATE COMPLIANCE	STANDARD	YES	NO	COMMENTS
The organization has a Corporate Compliance plan	**COM 1.0**			
The organization has written policies and procedures required for an effective compliance program that include the following:	**COM 1.0.1**			
a. Designating a Compliance Officer;	**COM 1.0.1(a)**			
b. Having written Standards of Conduct that include a non-retaliation statement;	**COM 1.0.1(b)**			
c. Following procedures to prevent, detect, and correct Fraud, Waste, and Abuse;	**COM 1.0.1(c)**			
d. Performing a Risk Assessment that addresses areas of vulnerability;	**COM 1.0.1(d)**			

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

e. Utilizing continuous Quality Improvement techniques (e.g. auditing, problem identification, investigation, and corrective action); and	**COM 1.0.1(e)**			
f. Following disciplinary and corrective action plans when non-compliance is suspected.	**COM 1.0.1(f)**			
Evidence exists that staff has been trained on all elements of the Corporate Compliance Plan upon-hire and annually. When interviewed, staff is knowledgeable of the Standards of Conduct for the organization.	**COM 1.0.2**			
The organization is in good standing with Medicare/Medicaid programs	**COM 2.0**			
The organization, which participates in the Medicare/Medicaid program, has been free of sanctions for a period of at least 2 years.	**COM 2.0.1**			
The organization takes steps at on-boarding (and annually) to prohibit the employment or contracting of individuals or companies that have been convicted of a criminal felony offense related to healthcare.	**COM 2.0.2**			
a. There is evidence of verification of individuals through the OIG exclusion database, www.oig.hhs.gov	**COM 2.0.2(a)**			
The organization's staff are licensed, certified, or registered in accordance with applicable State laws.	**COM 3.0**			
The organization has a written process verifying applicable personnel are licensed, certified, or registered, as required by State law.	**COM 3.0.1**			
This information is documented and tracked in an organized format.	**COM 3.0.2**			
ADMINISTRATION	**STANDARD**	**YES**	**NO**	**COMMENTS**
The organization has a governing body or individual having legal responsibility for the conduct of the organization.	**ADM 1.0**			
The organization has proof of ownership.	**ADM 1.0.1**			
The organization reports any change in ownership to The Compliance Team.	**ADM 1.0.2**			
The organization has an organizational chart.	**ADM 1.0.3**			
The organization has a protocol that identifies who is in charge of day-to-day operations in the absence of key leadership.	**ADM 1.0.4**			
The organization follows written policies and procedures for the maintenance of patient health records.	**ADM 2.0**			
The organization has written policies and procedures to ensure patient health records are maintained in accordance with policy. The policies include:	**ADM 2.0.1**			

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

a. Having a patient health record for every person receiving services by the organization.	**ADM 2.0.1(a)**			
b. Designating a member of the organization's professional staff who is responsible for the maintenance of patient health records by ensuring they are:	**ADM 2.0.1(b)**			
i. Complete and accurately documented.	**ADM 2.0.1(b)(i)**			
ii. Readily accessible and systematically organized.	**ADM 2.0.1(b)(ii)**			
iii. Complete when patients are referred or transferred.	**ADM 2.0.1(b)(iii)**			
The organization follows written policies and procedures addressing protected health information.	**ADM 3.0**			
The organization has written policies and procedures addressing protected health information (PHI) that address the use, security, and removal of patient health records as required by current HIPAA regulations. The policies and procedures include:	**ADM 3.0.1**			
a. Describing the steps taken by staff to ensure a patient's privacy during the provision of service and on-going confidentiality is maintained;	**ADM 3.0.1(a)**			
b. Ensuring safeguards are in place to protect health information against loss, destruction, and unauthorized use;	**ADM 3.0.1(b)**			
c. Publicly posting a privacy notice and making it available to all patients at time of initial contact;	**ADM 3.0.1(c)**			
d. Requiring a patient's consent for the release of PHI before any information not authorized by law is released;	**ADM 3.0.1(d)**			
e. Ensuring Business Associate Agreements (BAA) are in place when an entity or contractor, having access to PHI, is engaged by the organization; and	**ADM 3.0.1(e)**			
f. Maintaining patient health records, at a minimum, 6 years from the last date of entry or longer if required by State statute.	**ADM 3.0.1(f)**			
Evidence exists that all staff is trained on patient privacy, confidentiality, and HIPAA regulations upon-hire and annually.	**ADM 3.0.2**			
HUMAN RESOURCES	**STANDARD**	**YES**	**NO**	**COMMENTS**
The organization follows written policies and procedures for hiring, orientating, and training all staff.	**HR 1.0**			
The organization has written policies and procedures for human resources that are consistent with the needs for the services it provides to its beneficiaries. The policies include:	**HR 1.0.1**			

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

a. Specifying personnel qualifications and experience requirements.	**HR 1.0.1(a)**			
b. Specifying training, competency, and continuing education requirements.	**HR 1.0.1(b)**			
Evidence exists of staff training and validation of competency upon hire, annually, when new services are added, or when a staff member's performance warrants it.				
The organization has written job descriptions for all staff.	**HR 2.0**			
The organization has written job descriptions (or checklists) outlining all staff members' responsibilities and accountabilities.	**HR 2.0.1**			
Evidence exists that staff members' job descriptions are signed, dated, and placed in their personnel file	**HR 2.0.2**			
The organization maintains personnel files on all employees and independent contractors	**HR 3.0**			If no, please see personnel audit tool below for additional detail.
RISK MANAGEMENT	**STANDARD**	**YES**	**NO**	**COMMENTS**
The organization has a written process for receiving, reviewing, and preventing patient incidents.	**RSK 1.0**			
The organization has evidence that incidents are documented on a specific form. The organization can provide a copy of this form upon request.	**RSK 1.0.1**			
There is a designated staff member responsible for reviewing all incidents and a process in place for taking corrective action and following-up. If the incident results in hospitalization or death, it is reported to TCT within 48 hours.	**RSK 1.0.2**			
Evidence exists that employees have been trained and are knowledgeable of the process.	**RSK 1.0.3**			
The organization has a written process for handling employee injuries or exposures.	**RSK 2.0**			
The organization has evidence that employee incidents, injuries or exposures are documented on a specific form.	**RSK 2.0.1**			
There is a designated staff member responsible for reviewing all incidents and a process in place for taking corrective action and following-up. If the incident results in hospitalization or death, it is reported to TCT within 48 hours.	**RSK 2.0.2**			
Employee incidents, injuries or exposure are documented on an incident form.	**RSK 2.0.3**			
Evidence exists that employees have been trained and are knowledgeable of the process	**RSK 2.0.4**			
EQUIPMENT MANAGEMENT	**STANDARD**	**YES**	**NO**	**COMMENTS**

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

The organization follows written policies and procedures for equipment management.	**EQP 1.0**			
The organization's equipment management policies and procedures clearly state the process for cleaning, maintaining and storing all equipment. Policies include the following requirements:	**EQP 1.0.1**			
a. All equipment, including equipment loaned to patients (e.g., crutches, wheelchairs or walkers), is cleaned with a healthcare disinfectant according to manufacturer's directions and kept sanitary prior to each patient's use.	**EQP 1.0.1(a)**			
b. Equipment/supplies are stored on shelves, in cabinets and off the floor.	**EQP 1.0.1(b)**			
c. Defective and obsolete equipment is appropriately labeled.	**EQP 1.0.1(c)**			
The organization's equipment management policies and procedures address specialty compliance concerning the storage of oxygen tank as applicable:	**EQP 1.0.2**			
a. All oxygen tanks are properly secured and maintained in a well-ventilated area.	**EQP 1.0.2(a)**			
b. If multiple oxygen tanks are maintained, full tanks are stored separately from those that are empty or partially full.	**EQP 1.0.2(b)**			
The organization has written policies and procedures describing a preventive maintenance program to ensure that:	**EQP 1.0.3**			
a. All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition.	**EQP 1.0.3(a)**			
i. Equipment is inspected/tested according to manufacturer's guidelines and assessed prior to patient use to ensure it is in working order.	**EQP 1.0.3(a)(i)**			
ii. Evidence exists of all preventive maintenance or repairs.	**EQP 1.0.3(a)(ii)**			
INFECTION CONTROL	**STANDARD**	**YES**	**NO**	**COMMENTS**
The organization follows infection prevention techniques that relate to the type of patient served, services provided and the staff's risk for exposure.	**INF 1.0**			
The organization has a written infection control policy and procedure reviewed annually.	**INF 1.0.1**			
The organization practices infection prevention techniques by utilizing the following:	**INF 1.0.2**			
a. Hand washing or use of alcohol-based gel before and after each patient contact.	**INF 1.0.2(a)**			
b. Utilization of gloves while handling or cleaning dirty equipment.	**INF 1.0.2(b)**			

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

c. Proper disposal of gloves, sharps and other waste throughout the practice including red bag use.	**INF 1.0.2(c)**			
d. Standard Precautions when at risk for exposure to blood-borne pathogens.	**INF 1.0.2(d)**			
e. Prevents cross-contamination by segregating clean from dirty in utility and or storage areas.	**INF 1.0.2(e)**			
All sterilization equipment and procedures follow manufacturer guidelines for use.	**INF 1.0.3**			
a. All instruments are cleaned and sterilized according to the manufacturer's instructions for use.	**INF 1.0.3(a)**			
b. All sterile packaging has an identifiable expiration due date (if required by manufacturer guidelines).	**INF 1.0.3(b)**			
The organization's personnel receive education and training on infection control annually.	**INF 1.0.4**			
PATIENT SERVICES	**STANDARD**	**YES**	**NO**	**COMMENTS**
The organization has a process to protect the patient's rights and responsibilities.	**PTS 1.0**			
The organization has a written patient rights and responsibilities document which is posted and available to patients upon request.	**PTS 1.0.1**			
Evidence exists that staff has been trained and are knowledgeable on the patient rights and responsibilities document.	**PTS 1.0.2**			
The organization provides written information to all patients, or when appropriate, the patient's representative, as allowed by State law, upon admission to services.	**PTS 2.0**			
The organization has a process that information given to patients (or when appropriate, the patient's representative as allowed by State law) contains individual rights under State law to make decisions concerning medical care which includes:	**PTS 2.0.1**			
Attaining written consent to treat.	**PTS 2.0.1(a)**			
Accepting or refusing care.	**PTS 2.0.1(b)**			
Determining the relationship of an authorized representative for all minors and adult patients not capable of giving their consent	**PTS 2.0.1(c)**			
PHARMACEUTICAL SERVICES	**STANDARD**	**YES**	**NO**	**COMMENTS**
The organization has written policies and procedures for the storage, handling and dispensing of drugs and biologicals	**DRG 1.0**			
The organization's written policies and procedures include:	**DRG 1.0.1**			

a. Requirements that drugs are stored in original manufacturer's containers to maintain proper labeling.	**DRG 1.0.1(a)**			
b. Requirements that multiple dose vials and single dose vials are stored according to manufacturer guidelines.	**DRG 1.0.1(b)**			
c. Requirements that drugs and biologicals dispensed to patients have complete and legible labeling of containers;	**DRG 1.0.1(c)**			
d. Requirements for a process to regularly monitor the inventory of the organization's drugs, biologicals, and supplies for expiration by the manufacturer's date, beyond-use-dating, or evidence of recall.	**DRG 1.0.1(d)**			
e. Requirements for a process to handle outdated, deteriorated, or adulterated drugs, biologicals, and supplies. These are stored separately and the disposal is in compliance with applicable State laws.	**DRG 1.0.1(e)**			
f. Requirements for storage in a space that provides proper humidity, temperature, and light to maintain quality of drugs and biologicals that includes the following:	**DRG 1.0.1(f)**			
i. Refrigerated or frozen medication or vaccines are monitored for storage temperature at least twice daily.	**DRG 1.0.1(f)(i)**			
ii. Temperatures are recorded in a log and staff reports variances in normal findings to organizational leadership.	**DRG 1.0.1(f)(ii)**			
iii. No drugs or biologicals are stored in the door of the refrigerator or freezer.	**DRG 1.0.1(f)(iii)**			
iv. Water bottles are placed in the door of the medication refrigerator to promote temperature stability.	**DRG 1.0.1(f)(iv)**			
g. Requirements that current drugs references, antidote information, and manufacturer's guidelines are available on the premises.	**DRG 1.0.1(g)**			
h. All controlled substances are handled, as directed by the Drug Enforcement Agency (DEA) Practitioner's Manual, in a manner that guards against theft and diversion.	**DRG 1.0.1(h)**			
i. Schedule II drugs are stored in a securely constructed locked compartment, separate from other drugs.	**DRG 1.0.1(h)(i)**			
ii. Schedule III, IV, and V drugs are secured in a substantially constructed cabinet.	**DRG 1.0.1(h)(ii)**			
iii. The organization maintains adequate record keeping of the receipt of controlled drugs and a reconcilable log of the distribution. Should Schedule II drugs be administered in the organization, these drugs are accounted for	**DRG 1.0.1(h)(iii)**			

separately. Any thefts or significant losses are reported to the DEA.				
i. Requirements that containers used to dispense drugs and biologicals to patients conform to the Poison Prevention Packaging Act of 1970;	**DRG 1.0.1(i)**			
j. Requirements that all prescribing and dispensing of drugs shall be in compliance with applicable State laws.	**DRG 1.0.1(j)**			
k. Drugs, Biologicals, and Supplies are appropriately stored.	**DRG 1.0.1(k)**			
i. All sharps, chemicals and electrical hazards are secured.	**DRG 1.0.1(k)(i)**			
DIAGNOSTIC SERVICES	**STANDARD**	**YES**	**NO**	**COMMENTS**
The organization provides basic laboratory services essential to immediate diagnosis and treatment as applicable	**DGS 1.0**			
The organization has an appropriate CLIA.	**DGS 1.0.1**			
Evidence exists that all staff performing lab services have been trained and their competency validated upon-hire and annually	**DGS 1.0.2**			
REGULATORY	**STANDARD**	**YES**	**NO**	**COMMENTS**
The organization is in compliance with applicable local, State, and Federal laws or regulations	**REG 1.0**			
The organization is licensed in accordance with applicable State and local laws.	**REG 1.0.1**			
The organization displays all licenses, certificates and permits to operate, as required.	**REG 1.0.2**			
The organization is in compliance with the OSHA Blood-Borne Pathogen Standard as it relates to the type of patient served, services provided, and staff's risk for exposure.	**REG 2.A**			
The organization has a written work-exposure plan that determines the job classifications of staff at risk of blood-borne pathogen exposure and the work-practice controls and personal protective equipment (PPE) that are made available to protect them. The plan is reviewed and/or updated at least annually.	**REG 2.A.1**			
All PPE is provided by the employer and is readily accessible to staff.	**REG 2.A.2**			
If identified as being at risk for exposure to blood-borne pathogens, the staff member is offered full Hepatitis B vaccination series at the employer's expense. If declined, a signed declination form appears in the personnel file.	**REG 2.A.3**			
Evidence exists that all staff have received training on the OSHA Bloodborne Pathogens Standard upon-hire and annually.	**REG 2.A.4**			

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

The organization is in compliance with the current OSHA and CDC guidelines for preventing the transmission of Myobacterium Tuberculosis in health care settings.	**REG 2.B**			
The organization conducts an initial and on-going risk assessment for TB transmission by occupational exposure. Factors to be considered may include: risk by geographical location as determined by the State Department of Health, the type of patient population served (including fluctuations of population caused by temporary workers or tourism), and the reported cases of TB in the organization in the past year.	**REG 2.B.1**			
Based upon assessment of risk, the organization follows current OSHA and CDC guidelines to determine the types of administrative, environmental, respiratory protection controls, and medical surveillance needed.	**REG 2.B.2**			
There is evidence the organization conducts TB screening upon hire.	**REG 2.B.3**			
Evidence exists that all staff have received TB transmission prevention training upon-hire and annually.	**REG 2.B.4**			
The organization is in compliance with OSHA's Right to Know Standard	**REG 2.C**			
Safety Data Sheets (SDS) are available for all hazardous material in the organization's workplace and employees are knowledgeable of the location of the references.	**REG 2.C.1**			
The organization posts all mandatory OSHA posters for all employees to view.	**REG 2.C.2**			
Evidence exists that staff is trained on identifying hazards in the workplace.	**REG 2.C.3**			
The organization has an emergency preparedness plan that addresses an emergency on-site (natural disaster) and disruption of services.	**REG 2.D**			
The organization has a written emergency preparedness plan with an organized process for handling an on-site emergency, (e.g., fire, active shooter) addressing the following:	**REG 2.D.1**			
a. How employees will be notified of emergency;	**REG 2.D.1(a)**			
b. Which staff member is responsible for calling 911;	**REG 2.D.1(b)**			
c. The location where employees should meet outside the building; and	**REG 2.D.1(c)**			
d. The staff person designated to do head count upon evacuation of the building	**REG 2.D.1(d)**			
Fire Safety requirements are met as follows:	**REG 2.D.2**			
a. Fire extinguisher is mounted and has been checked and approved for use.	**REG 2.D.2(a)**			
b. Upon on hire and annual in-service for all employees on Fire Safety (including how to operate an extinguisher).	**REG 2.D.2(b)**			

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

The organization has a written emergency preparedness plan with an organized process for handling an off-site emergency, (e.g. snowstorm, flood, etc.) addressing the following:	**REG 2.D.3**			
a. How employees will be notified of emergency;	**REG 2.D.3(a)**			
b. Which staff member is responsible for notification of patients;	**REG 2.D.3(b)**			
c. How refrigerated medications are handled during a power outage; and	**REG 2.D.3(c)**			
d. How it will implement a contingency plan, that includes routing patients to an alternative provider in the event the organization cannot see its own patients for an extended period of time.	**REG 2.D.3(d)**			
Evidence exists of annual emergency preparedness staff training in personnel files or training records	**REG 2.D.3**			

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

Licensed Staff Member	State of Origin License # (or Certificate #)	License Expiration Date	DEA Certificate # (as applicable)	DEA Expiration Date	Verification & copies of professional license, registration and/or certification is maintained if applicable.

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

Personnel File Audit Tool **Insert "Y" (YES) if evidence is found, "N" (NO) if evidence of is missing, or "NA" if not applicable.**												
Staff Member	**W-4, I-9 for Employees (HR 3.0.1(a))**	**Curriculum Vitae, Application or Resume with references (HR 3.0.1(b)**	**Signed Job Description or contractual agreement. (HR 3.0.1(c)**	**Orientation/Training/Competency Assessment checklists (HR 3.0.1(d))**	**Signed Standard of Conduct (HR 3.0.1(e))**	**Current License or Certification (HR 3.0.1(f))**	**OIG Exclusion (HR 3.0.1(g)**	**Annual Performance Evaluation (HR 3.0.1(h))**	**Background Check (HR 3.0.1(i)**	**Hepatitis B (HR 3.0.1(j))**	**TB (HR 3.0.1(k))**	**Copy of current BLS or higher (ACLS, PALS) when required by organizational policy for all licensed personnel (HR 3.0.1(l)**	**Comments**

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

REQUIRED EMPLOYEE TRAINING DOCUMENTATION REVIEW

Click on the standard to view the full requirement.

Staff Member	Corporate Compliance Plan (hire/annual) COM 1.0.2	Patient Privacy, Confidentiality & HIPPA (hire/annual) ADM 3.0.2	Training/Competency Validation (hire/annual/ new services & performance HR 1.0.2	Patient Incidents RSK 1.0.3	Employee Incidents/Injuries/Exposures RSK 2.0.4	Infection Control INF 1.0.4	Patient Rights & Responsibilities PTS 1.0.2	Lab Services Training/Competency Validation (hire/annual) (if performing) DGS 1.0.2	OSHA Blood-borne Pathogens (hire/annual) REG 2.A.4	TB Transmission Prevention (hire/annual) REG 2.B.4	Identifying Hazards in Workplace REG2.C.3	Fire Safety & Extinguisher REG 2.D.2(b)	Assessment & Addressing Patient Needs PCMH 3.0.2 ; PCMH 2.0.2 (a-e)	Comments

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

DE-IDENTIFIED PATIENT HEALTH RECORDS REVIEWED

1		**6**	
2		**7**	
3		**8**	
4		**9**	
5		**10**	

PATIENT HEALTHCARE RECORD REVIEW

PCMH Standard Requirement	1	2	3	4	5	6	7	8	9	10	Comments
Identification of individual included in care/healthcare decision of patients (PCMH 8.0.1(a)(i))											
Preferred language (PCMH 8.0.1(a)(ii))											
Properly executed consent to treat (PCMH 8.0.1(b)(i))											
Identification of relationship to minor patient, if applicable (PCMH 8.0.1(b)(ii))											
Copy of Advance Directive in healthcare record if applicable (PCMH 8.0.1(c)(i))											
Pertinent Medical History (PCMH 8.0.1(d))											
Vital signs (PCMH 8.0.1(e)(i))											
Gender, Height, Weight, Assessment of BMI, growth percentile (PCMH 5.0.1(e)(ii)											
Chief Complaint (PCMH 8.0.1(e)(iii)											
Behavior health screening when depressive symptoms identified (PCMH 8.0.1(e)(iv)											
Cognitive Screening (PCMH 8.0.1(e)(v))											
Preventive-health measures (PCMH 8.0.1(e)(vi))											
Updated Needs Assessment, as appropriate (PCMH 8.0.1(e)(vii))											
Updated Patient-Centered Health Improvement Plan (PCHIP™) (PCMH 8.0.1(e)(viii)											
Updated patient health goals (as appropriate and defined by the organization (PCMH 8.0.1(e)(ix))											
Summary of encounter and patient instructions (PCMH 8.0.1(f)											

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

PCMH Standard Requirement	1	2	3	4	5	6	7	8	9	10	Comments
Reports, consultation notes, and information pertinent to monitor the patient progress (PCMH 8.0.1(g)											
Provider Orders and Documentation of Tests/Treatments/Medications Administered (PCMH 8.0.1(h)											
Documentation & Reconciliation of Medications (PCMH 8.0.1(i))											
Signature and Date of Provider related to encounter (PCMH 8.0.1(j))											
Identification of Provider/Care Team assigned to the Patient (PCMH 8.0.1(k))											
Identification of Patients Pharmacy by name, location and contact info (PCMH 8.0.2(l))											
Patient education provided to patient & family/caregivers (PCMH 3.0.2)											
Follow-up communication with patients (PCMH 5.0.2)											

NOTE: MULTIPLE DEFICIENCIES IDENTIFIED DURING THE PATIENT HEALTH CARE RECORD REVIEW ARE CITED UNDER PCMH 8.0

***Review of Patient Health Records of Minor Patient- Please include (M) after the patient identifier.**

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

REQUIRED WRITTEN POLICIES, PROCEDURES, PROTOCOLS & PLANS

Click on the standard to view all requirements related to the identified policy/procedure/protocol.

REQUIRED DOCUMENTS	STANDARDS 2019	CURRENT STANDARDS	REVIEWED
Corporate Compliance Policies and Procedures	**COM 1.0.1**	**COM 1.0.1**	
Verifying License, Certification or Registration	**COM 3.0.1**	**COM 3.0.1**	
Maintenance of Patient Health Records	**ADM 2.0**	**ADM 2.0**	
Protecting Patient Health Records	**ADM 3.0**	**ADM 3.0**	
Hiring, Orienting, and Training Staff	**HR 1.0**	**HR 1.0**	
Patient Satisfaction Issue Resolution	**QI 1.0.3**	**QI 1.0.3**	
Patient Complaints	**QI 1.0.4**	**QI 1.0.4**	
Continuous Quality Improvement Related to Patient-Centered Medical Home Care Model	**QI 2.0**	**QI 2.0**	
Quality Improvement Activities for the Patient-Centered Medical Home	**QI 2.0.1**	**QI 2.0.1**	
Program Evaluation Annually	**QI 2.0.2**	**QI 2.0.2**	
QI Data Collection, Analysis, Findings, action plans, Follow-up, and Annual Program Evaluation	**QI 2.0.3**	**QI 2.0.3**	
Infection Control (and reviewed annually)	**INF 1.0**	**INF 1.0**	
Drugs & Biologicals – Storage, Handling, and Dispensing	**DRG 1.0**	**DRG 1.0**	
Patient Incidents	**RSK 1.0**	**RSK 1.0**	
Employee Injuries & Exposures	**RSK 2.0**	**RSK 2.0**	
Equipment Management	**EQP 1.0**	**EQP 1.0**	
Preventive Maintenance	**EQP 1.0.3**	**EQP 1.0.3**	
Work-Exposure Plan	**REG 2.A.1**	**REG 2.A.1**	
Emergency Preparedness Plan	**REG 2.D.1**	**REG 2.D.1**	
Patient Communication Plan	**PCMH 1.0.5**	**PCMH 4.0.5**	
Implementation Plan for Patient Centered Medical Home	**PCMH 3.0.1**	**PCMH 1.0.1**	
Care Coordination Protocol	**PCMH 3.0.4(a)**	**PCMH 1.0.4(a)**	
Improving Efficiency in Delivery of Care	**PCMH 6.0.1**	**PCMH 7.0.1**	
Patient-Centered Health Improvement Plan™ (PCHIP™)	**PCMH 7.0.1**	**PCMH 2.0.1**	
Continuity of Care	**PCMH 9.0.1**	**PCMH 5.0.1**	

Facility Name/Clinic:	Surveyor Number(s):	Survey Date(s):
	Time In: Time Out:	Hours Onsite:

PATIENT INTERVIEWS

PCMH Patient Questions	Patient Interview (1)	Patient Interview (2)
Are you able to easily get an appointment?		
Do you understand what a PCMH is?		
Have you noticed anything different since the practice became a PMCH?		
Do you understand your diagnosis?		
Do you have follow-up instructions?		
Enough time spent to ask all questions?		
Can you easily reach your care team?		
Do you use the clinic's portal for information?		
Grade for the Clinic?		
Comments		

Patient Centered Medical Home: A Practice Model to Improve Quality
Session 3, Handout 2
How to conduct a PCMH Self-Mock Survey

1. Conduct a self-mock survey using TCT's PCMH Checklist by reviewing each item listed and recording your answer.
2. Mark each item as compliant (Yes) or noncompliant (No). If the clinic is noncompliant, please document information why in comment section of the checklist for discussion with your staff once the self-survey is final.
3. Fill out Licensed Personnel Audit Tool for all licensed, registered, and/or certified personnel.
    a. If the individual field does not apply to that staff member, simply insert N/A. For example, if the staff member has been employed less than one year, N/A is an appropriate entry for the performance evaluation. In the comment section below-explain each N/A entry. If elements are missing from personnel files, make sure you discuss with HR to ensure all files are complete prior to onsite survey.
4. Randomly select 10 PCMH patient health records that have been seen in the clinic in the past 2-3 weeks and conduct an audit marking each entry as Y or N or N/A if there were no labs ordered that day. The sample must include at least two patients that had a lab order and at least four over 65 years of age. Please do not include Telehealth patients. As you complete the patient healthcare record review, use the following unique identifier that protects PHI and consists of the following:

    a. Each patient health record reviewed will be assigned a unique identifier that consists of the following:

        i. A numerical number that identifies the record reviewed. For example, when the surveyor reviews the first record, it will be noted as number 1. The review of the second record will include the number 2, etc.;

        ii. A key that contains the first two initials of the last name, the date of service, followed by the first initial of the patient's first name; and

        iii. The date of service will be identified as a numerical number with a 2-digit month, the actual date of service and a 2-digit year. For instance, if the patient is seen in the clinic on February 1, 2018, the numerical identifier for the date of service would be 020118.

        iv. Using the method listed above, an example of a unique identifier for the first record reviewed of a patient named John Doe, seen in the clinic on February 1, 2018 would be: 1Do020118J. If the patient is a minor, identify with the letter M at the end of the sequence 1Do020118JM

5. Review all items on the PCMH checklist marked NO and address those items with your team. This is an open book test using the same checklist the surveyor will use so you should be able to answer Yes to all items on the checklist.
6. Once the PCMH self-mock survey is complete and all items answered Yes, you are ready for a TCT onsite survey.