AmeriHealth Caritas Family of Companies (ACFC) Guide for PCMH Program

This guide is one tool in the PCMH toolkit designed to assist collaborating practices with practice transformation, and preparing for any desired certification or recognition as well as performance improvement. The sequence of the measures and related notes reflect those activities that are anticipated to have the most impact in improving outcomes and reducing unnecessary utilization and costs for our member population.

Note: Must Pass: These are considered to be critical elements for PCMH transformation and NCQA PCMH recognition.

Care Management and Support (PCMH 4)			
Points: 20	Category	Document Equivalent	Requires Report (Y = Yes)
4	Element A – Identify Patients for Care Management The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following: ➢ Behavioral health conditions ➢ High cost/high utilization ➢ Poorly controlled or complex conditions ➢ Social determinants of health ➢ Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver ➢ The practice monitors the percentage of the total patient population identified through its process and criteria		
4	**Element B –Care Planning and Self Care Support – MUST PASS** **The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75% of patient identified in Element A:** ➢ **Incorporates patient preferences and functional/lifestyle goals** ➢ **Identifies treatment goals** ➢ **Assesses and addresses potential barriers to meeting goals** ➢ **Includes a self-management plan** ➢ **Is provided in writing to the patient/family/caregiver**	*Factors 1-5:* Report from electronic system or submission of Record Review Workbook and examples showing each required data element	Y
4	Element C- Medication Management ➢ Reconcile patient medications at visits and post-hospitalizations		
3	Element D – Use Electronic Prescribing ➢ Uses e-prescribing		
5	Element E - Support Self-Care and Shared Decision-Making ➢ Uses an EHR to identify patient-specific education resources and provide them to more than 10		

	percent of patients+ ➢ Provides educational materials and resources to patients ➢ Provides self-management tools to record self-care results ➢ Adopts shared decision making aids ➢ Offers or refers patients to structured health education programs such as group classes and peer support ➢ Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates ➢ Assesses usefulness of identified community resources. ➢ + Stage 2 Core Meaningful Use Requirement		

Sample Resources for Practices and Coaches: Care Management and Support

www.medicalhomeinfo.org

- Pediatric care plan
- Action plan template
- Care Guideline
  - Asthma
  - ADHD

https://www.communitycarenc.org/emerging-initiatives/pcmh-central1/2011-pcmh-resources/

- Specific tools to consider: (https://www.communitycarenc.org/media/files/web-based-pcmh-2011-workbook-1-xls.xls)
  - Asthma Action Plan
  - Red Yellow Green Diabetes Action Plan
  - Barriers to Care Screenshot
  - PPC3A – dsmepathway
  - PPC3C – Standing fluorder
  - Local Education Agency referral form
- Safety Net Medical Home Initiative (http://www.safetynetmedicalhome.org/)
- Storyboards from practices (http://www.safetynetmedicalhome.org/resources-tools/peer-learning/2011-summit-materials/storyboards)
- Care Coordination Toolkit (http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Care-Coordination.pdf
- Free Webinars/information – Learning community – care coordination and health coaching (http://clinicalhealthcoach.com/)
- Practice Best Practice Examples, (Community Health Workers, Coordinated care and appropriate use of ER) (http://www.oregon.gov/oha/news/Pages/ArticleListHealthcareProviders.aspx)
- Patient engagement and self-management tools (https://www.communitycarenc.org/provider-tools/)

Team Based Care (PCMH 2)			
Points 12	Category	Document Equivalent	Requires Report (Y = Yes)
4	**Element D: The Practice Team - MUST-PASS** **The practice uses a team to provide a range of patient care services by:** **1. Defining roles for clinical and nonclinical team members** **2. Identifying practice organizational structure and staff leading and sustaining team based care** **3. Having regular patient care team meetings or a structured communication process focused on individual patient care** **4. Using standing orders for services** **5. Training and assigning members of the care team to coordinate care for individual patients** **6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change** **7. Training and assigning members of the care team to manage the patient population** **8. Holding regular team meetings addressing practice functioning** **9. Involving care team staff in the practice's performance evaluation and quality improvement activities** **10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council**	**Documentation** • *Factors 1,5,6,7:* Staff position descriptions or responsibilities and • *Factor 3:* Description of staff communication processes and at three examples • *Factor 4:* At least one example of written standing orders • *Factors 5-7:* Description of training process, schedule, materials • *Factor 8:* Description of staff communication processes and sample • *Factor 9:* Description of staff role in practice improvement process or minutes demonstrating staff involvement • *Factor 10:* Dated documented process demonstrating how it involves patients/families in QI teams or advisory council	
3	Element A- Continuity ➢ Request that patients select a personal clinician, document selection and monitor % that have made selection. ➢ Having a process to orient new patients to the practice	Need Policy	Y (Screenshot)
2.5	Element B- Medical Home Responsibilities ➢ Coordinate care across multiple settings ➢ Provide Instructions for obtaining care and clinical advice during and after office hours ➢ The scope of services available within the practice	Need Policy Example of patient Brochure, website, patient compact	

	including how behavioral health needs are addressed ➢ The practice provides equal access to all of their patients regardless of source of payment		
2.5	Element C– Culturally and Linguistically Appropriate Services ➢ Assess racial and ethnic diversity and language needs of population ➢ Provide interpretation and printed materials to meet needs	Need Policies and Examples	Y

Sample resources: Team Based Care

Team based planning guidelines (http://www.safetynetmedicalhome.org/resources-tools/all-resources)

Optimize the Care Team (http://www.ihi.org/resources/Pages/Changes/OptimizetheCareTeam.aspx)

Individual and Family Engagement in the Medicaid Population: Emerging Best Practices and Recommendations (www.ipfcc.org)

Performance Measurement and Quality Improvement (PCMH 6)			
Points 20	Category	Document Equivalent	Requires Report (Y = Yes)
3	Element A: Measure Clinical Quality Performance ➢ At least 2 immunization measures ➢ At least 2 other preventive care measures ➢ At least 3 chronic or acute care measures ➢ At least two utilization measures affecting health care costs ○ Participate in reducing avoidable ER visits ○ Participate in reducing avoidable hospital admissions ○ Participate in generic medication utilization ➢ Performance data stratified for vulnerable populations	Reports showing performance and improvement	Y
3	Element B- Measure Resource Use and Care Coordination ➢ At least annually, the practice measures or receives quantitative data on: 1. At least two measures related to care coordination 2. At least two measures affecting health care costs		Y
4	Element C- Measure Patient/Family Experience ➢ Conduct a survey on at least 3 categories ➢ Use CAHPS PCMH survey tool ➢ Obtain feedback on the experiences of vulnerable patient groups ➢ Obtain feedback from patients through qualitative means. Show how practice team reviews survey results and addresses performance gaps		
4	**Element D- Implement Continuous Quality Improvement – MUST PASS*** **The practice uses an ongoing quality improvement process**		Y

	to: ➢ **Set goals and analyze at least three clinical quality measures from Element A** ➢ **Act to improve at least three clinical quality measures from Element A** ➢ **Set goals and analyze at least one measure from Element B** ➢ **Act to improve at least one measure from Element B** ➢ **Set goals and analyze at least one patient experience measure from Element C** ➢ **Act to improve at least one patient experience measure from Element C** ➢ **Set goals and address at least one identified disparity in care/service for identified vulnerable populations**		
3	Element E- Demonstrate Continuous quality improvement The practice demonstrates continuous quality improvement by: ➢ Measuring the effectiveness of the actions it takes to improve the measures selected in Element D ➢ Achieving improved performance on at least two clinical quality measures ➢ Achieving improved performance on one utilization or care coordination measure ➢ Achieving improved performance on at least one patient experience measure		Y
3	Element F – Report Performance ➢ Within the practice, results by individual clinician ➢ Within the practice, results across the practice ➢ Outside the practice to patients or publicly , results across the practice or by clinicians		Y
	Element G – Use Certified EMR Technology (Not Scored)		Y

Sample Resources: Performance Measurement and Quality Improvement

http://forces4quality.org/tale-three-practices-how-medical-groups-are-improving-patient-experience
Best Practices: Improving the patient experience of care
http://www.pcpci.org/resources/browse/topic/53/type/60
Various resources/best practices for ongoing quality and performance improvement
http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx
Quality improvement tools
http://www.chcf.org/topics/care-delivery
Various tools for practice transformation/improving outcomes
https://www.communitycarenc.org/emerging-initiatives/pcmh-central1/2011-pcmh-resources/

Safety Net Medical Home Initiative
http://www.safetynetmedicalhome.org/
http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide- I-Strategy-2.pdf

http://www.safetynetmedicalhome.org/sites/default/files/A3.pdf

Patient-Centered Access (PCMH 1)			
Points 10	Category	Document Equivalent	Requires Report (Y = Yes)
4.5	Element A – Access During Office Hours – MUST PASS* ➢ **Provide same day appointments for routine and urgent care** ➢ **Providing routine and urgent-care appointments outside regular business hours** ➢ **Providing alternative types of clinical encounters** ➢ **Availability of appointments** ➢ **Monitoring no show rates** ➢ **Acting on identified opportunities to improve access**	Need Policies	Y (1 week call log or report)
3.5	Element B – 24/7 Access to Clinical Care The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on: ➢ Providing continuity of medical record information for care and advice when the office is closed ➢ Providing timely clinical advice by telephone ➢ Providing timely clinical advice using a secure, interactive electronic system ➢ Documenting clinical advice in patient records	Policies	Y (proof of hours)
2	Element C – Electronic Access The following information and services are provided to patients/families/caregivers, as specified, through a secure electronic system. ➢ More than 50 percent of patients have online access to their health information within four business days of when the information is available to the practice+ ➢ More than 5 percent of patients view, and are provided the capability to download, their health information or transmit their health information to a third party+ ➢ Clinical summaries are provided within 1 business day(s) for more than 50 percent of office visits+ ➢ A secure message was sent to more than 5 percent of patients+ ➢ Patients have two-way communication with the practice ➢ Patients can request appointments, prescription refills, referrals and test results. ➢ +Stage 2 Core Meaningful Use Requirement	Screenshot demonstrating capability	

Sample Resources: Patient Centered Access

www.medicalhomeinfo.org

- Sample Practice Brochure

https://www.communitycarenc.org/emerging-initiatives/pcmh-central1/2011-pcmh-resources/

- Specific tools to consider: (https://www.communitycarenc.org/media/files/web-based-pcmh-2011-workbook-1-xls.xls)
    - Sample Practice Access Communication Policy
    - Sample Policy: Telephone and E-Mail Response (PCMH 1A3,4)
    - Sample Patient Portal Policy and Procedure
    - PPCA3 (https://www.communitycarenc.org/elements/media/files/ppc1a-35triagepolicy.pdf)

Safety Net Medical Home Initiative
http://www.safetynetmedicalhome.org/

- Strategies and Tools to Orient and Engage Patients and Families to the Patient-Centered Medical Home Model of Care (http://www.safetynetmedicalhome.org/sites/default/files/Intro-To-PCMH.pdf)
- Time to Third Next Available appointment (http://www.safetynetmedicalhome.org/sites/default/files/Third-Next-Appointment.pdf)

Population Health Management (PCMH 3)			
Points 20	Category	Document Equivalent	Requires Report (Y = Yes)
3 + 4	Element A and B - Patient Information and Clinical Data ➢ The practice collects demographic and clinical data for population management	Screenshot demonstrating capability (BMI calculation)	Y
4	Element C – Comprehensive Health Assessment	Policy or sample completed assessment (no PHI)	
5	**Element D – Use Data for Population Management - MUST PASS*** **At least annually the practice proactively identifies populations of patients and reminds them, or their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:** ➢ **At least 2 different preventive care services** ➢ **At least 2 different immunizations** ➢ **At least 3 chronic care services (use same 3 as for PCMH3)** ➢ **Patients for recently seen by practice** ➢ **Medication monitoring or alert**	Materials showing patient outreach	Y
4	Element E - Implement Evidence-Based Decision Support The practice implements clinical decision support + (e.g. point-of-care reminders) following evidence-based guidelines for: ➢ A mental health or substance use disorder ➢ A chronic medical condition		

	➢ An acute condition ➢ A condition related to unhealthy behaviors ➢ Well child or adult care ➢ Overuse/appropriateness issues		

Sample Resources: Population Health Management

https://www.communitycarenc.org/emerging-initiatives/pcmh-central1/2011-pcmh-resources/

- Specific tools to consider: (https://www.communitycarenc.org/media/files/web-based-pcmh-2011-workbook-1-xls.xls)
    - PPC2F-5 -
    - 2011 Quick Reference Guide (HEDIS QARR Measures)
    - PPC2F-4
    - PPC2F – 2.7
    - For 2A – Example Data Elements (Elizabeth Family Medicine)
    - PCMH2D Example Identifying Patients on Specific Medication
    - Example: Provider quick Reference Guide: Cholesterol Management Screening

Care Coordination and Care Transitions (PCMH 5)			
Points 18	Category	Document Equivalent	Requires Report (Y = Yes)
6	Element A – Test Tracking and Follow-up ➢ Track lab and imaging test results and share all Sample Resources Available results with patients ➢ Flag abnormal results for clinician ➢ Electronically track results ➢ More than 30 percent of laboratory orders are electronically recorded in the patient record+ ➢ More than 30 percent of radiology orders are electronically recorded in the patient record+ ➢ Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record+ ➢ More than 10 percent of scans and tests that result in an image are accessible electronically++	Need Policies and examples of how tracked/shared	Y
6	**Element B – Referral Tracking and Follow-up – MUST PASS*** ➢ **Considers available performance information on consultants/specialists when making referral recommendations** ➢ **Maintains formal and informal agreements with a subset of specialists based on established criteria** ➢ **Maintains agreements with behavioral healthcare providers** ➢ **Integrates behavioral healthcare providers within the practice site** ➢ **Give clinical reason for referral** ➢ **Track status** ➢ **Follow-up** ➢ **Establish agreements for co-management** ➢ **Ask patients about self-referrals**	Need Policies and Examples/Screenshots	Y

	➢ **Demonstrate capability for electronic exchange of key clinical data** ➢ **Provide electronic summary of care record for "important" referrals**		
6	Element C – Coordinate with Facilities and Care Transitions The practice: ➢ Proactively identifies patients with unplanned hospital admissions and emergency department visits ➢ Shares clinical information with admitting hospitals and emergency departments ➢ Consistently obtains patient discharge summaries from the hospital and other facilities ➢ Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit ➢ Exchanges patient information with the hospital during a patient's hospitalization ➢ Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners ➢ Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care+ ➢ +Stage 2 Core Meaningful Use Requirement	Need Policies and Examples Copy of written transition of care plan Screen shot	Y

Sample Resources: Care Coordination and Care Transitions

www.medicalhomeinfo.org

- Co-management Agreement (http://www.medicalhomeinfo.org/downloads/pdfs/CMESeries2-ComanagementAgreement.pdf)

https://www.communitycarenc.org/emerging-initiatives/pcmh-central1/2011-pcmh-resources/

- Specific tools to consider: (https://www.communitycarenc.org/media/files/web-based-pcmh-2011-workbook-1-xls.xls)
  - Referral Tracking Form
  - Referral Tracking Policy (Example)
  - ER Visit Follow-up Log

Safety Net Medical Home Initiative
http://www.safetynetmedicalhome.org/