2014 PCMH Site Validation Visit
Capabilities Review

Physician Organization: NPO
Practice Unit: Kalkaska Family Practice, P.C.
Date: 6/26/2014

AInitiative			Demo	Description	Notes:
1.0 Patient Provider Partnership				**Goal:** Expand the physician health care team & patient awareness of commitment to the PCMH Model. To improve quality of care by strengthening bond between patients and the care team.	
FIP	NIP	1.1	√	Communication process includes conversation with patient and member of the practice team. –Documentation, Tools, Staff Training, & Tracking Mechanism **Current Documentation Required**	
FIP	NIP	1.2	√	Systematic process to inform patients about PCMH Systematic process to outreach to patients not visiting office regularly.	
FIP	NIP	1.3	√	10% patients have partnership	
FIP	NIP	1.4	√	30% patients have partnership	
FIP	NIP	1.5	√	50% patients have partnership	
FIP	NIP	1.6	√	60% patients have partnership	
FIP	NIP	1.7	√	80% patients have partnership	
FIP	NIP	1.8	√	90% patients have partnership	
FIP	NIP	1.9	√	Providers ensure patients are aware that health care info is shared among care partners if necessary	
2.0 Patient Registry				**Goal:** Encourage PGIP Participants to establish a comprehensive patient registry that can be used to optimally manage a population of patients, ultimately will improve health status and decrease cost. A database that contains clinical data that will enable practitioners to manage their population of pts.	
FIP	NIP	2.1	√	Population-Diabetes or condition relevant to specialty	
FIP	NIP	2.2	√	Functional -includes services received at other sites that are necessary to manage chronic disease (Labs, IPA, ER, UCC, Meds at least 4/5)	
FIP	NIP	2.3	√	Functional- incorporates evidence based care guidelines	
FIP	NIP	2.4	√	Functional- actively using at point of care	
FIP	NIP	2.5	√	Functional- contains attributed practitioner	
FIP	NIP	2.6	√	Functional - used to identify gaps in care- communicated to patient	
FIP	NIP	2.7	√	Functional- used to flag gaps in care for ALL pts in registry.	
FIP	NIP	2.8	√	Functional-contains patient demographics	
FIP	NIP	2.9	√	Functional-fully electronic- direct feed Labs, IPA, ER, UCC, Meds **(must have 2.2)**	

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FIP	NIP	2.10	√	Population- Asthma	
FIP	NIP	2.11	√	Population- CAD (Coronary Artery Disease)	
FIP	NIP	2.12	√	Population- CHF (Congestive Heart Failure)	
FIP	NIP	2.13	√	Population- Includes 2 other chronic conditions	
FIP	NIP	2.14	√	Functional- incorporates preventive services (mams, paps,imms,well visits) & used for outreach	
FIP	NIP	2.15	√	Population- incorporates managed care plan patients	
FIP	NIP	2.16	√	Population- CKD (Chronic Kidney Disease)	
FIP	NIP	2.17	√	Population- Pediatric Obesity	
FIP	NIP	2.18	√	Population- Pediatric ADHD/ADD	
FIP	NIP	2.19	√	Population – Care Manager Identified	
3.0 Performance Reporting				**Goal:** To implement performance reporting technology that will allow physicians to receive feedback on their performance, reduce gaps in care and improve outcomes. May be provided by PO & should be reviewed regularly.	
FIP	NIP	3.1	√	Report tracking Diabetes patients	
FIP	NIP	3.2	√	Reports at PO/Practice Unit /PCP level	
FIP	NIP	3.3	√	Reports include at least 2 other chronic conditions	
FIP	NIP	3.4	√	Data in reports are validated and reconciled	
FIP	NIP	3.5	√	Trend reports – PO/SubPO aggregate data	
FIP	NIP	3.6	√	Report tracking Pediatric Obesity	
FIP	NIP	3.7	√	Reports include ALL current patients & preventive services	
FIP	NIP	3.8	√	Reports include clinical info from other sources (labs, IP, ED, UC, Meds) necessary to manage chronic care and preventive services **(must have 2.2)**	
FIP	NIP	3.9	√	Reports include specialists services	
FIP	NIP	3.10	√	Reports track Asthma	
FIP	NIP	3.11	√	Reports track CAD	
FIP	NIP	3.12	√	Reports track CHF	
FIP	NIP	3.13	√	Reports track ADHD/ADD	
FIP	NIP	3.14	√	Reports include Care Manager activity	
FIP	NIP	3.15	√	Quality Metrics are tracked & reported to external entities	

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4.0 Individual Care Management				**Goal:** To ensure that patients with chronic conditions receive organized planned care that also empowers the patient to take greater responsibility for their health. Ultimately will increase overall health status and decrease health care costs.	
FIP	NIP	4.1	√	All staff trained on PCMH, chronic care model and practice transformation **Current Documentation Required**	
FIP	NIP	4.2	√	ADVANCED CAP- Multidisciplinary team (include RN, DM educators, etc), regular team meetings, travel teams, ongoing communication with practice	
FIP	NIP	4.3	√	Evidence based care guidelines are used at point of care, flags gaps in care, guidelines assist with appointment time booking	
FIP	NIP	4.4	√	Patient Satisfaction/Office Efficiency Survey; Results quantified, aggregated, and tracked over time	
FIP	NIP	4.5	√	Develop action plans & goal setting patient specific for 1 chronic condition, incorporate in patient chart **Documentation Required**	
FIP	NIP	4.6	√	Appointment reminder & tracking no shows for 1 chronic condition	
FIP	NIP	4.7	√	System to ensure follow up for needed services for 1 chronic condition	
FIP	NIP	4.8	√	Planned visit- proactive, team approach to manage care during visit for 1 chronic condition. Identify team roles & responsibilities. **Documented Process Required**	
FIP	NIP	4.9	√	Group visit (2hrs, no more than 20 patients), must include 1 on 1 with MD	
FIP	NIP	4.10	√	Medication review during visit	
FIP	NIP	4.11	√	Develop action plans & goal setting offered to ALL chronic care /complex patients, incorporate in patient chart **Documentation Required**	
FIP	NIP	4.12	√	Appointment tracking and reminder for ALL patients	
FIP	NIP	4.13	-	System to ensure follow up for needed services for ALL patients	
FIP	NIP	4.14	√	Planned visits for ALL patients w/chronic conditions **Documented Process Required**	
FIP	NIP	4.15	√	Group visit for ALL patients	
FIP	NIP	4.16	√	Advance Care Planning; conversation with patients and documentation.	

AInitiative			Demo	Description	Notes:
FIP	NIP	4.17	√	Survivorship Plan; process in place once treatment is complete, documentation in chart, plan shared amongst patient's providers.	
FIP	NIP	4.18	√	Palliative Care; assessment process in place and shared amongst all care providers (including specialist). **Documentation Required**	
FIP	NIP	4.19	√	Process to idenfity patients who would benefit from care management services **Documentation Required**	
FIP	NIP	4.20	√	Process to inform patients about availability of care management services	
FIP	NIP	4.21	√	Inter-Discimplinary Team conduct case reviews **(must have 4.2)** **Documentation Required**	
5.0 Extended Access				**Goal:** To ensure all patients have comprehensive, timely access to health care services that are patient centered and culturally sensitive; that is delivered in the least intensive & most appropriate setting based on the patient's needs.	
FIP	NIP	5.1	√	Access to 24 hr decision maker by phone w/feedback loop	
FIP	NIP	5.2	-	On call has access to EMR/Registry & can update	
FIP	NIP	5.3	-	8 after hours available (non ED - Urgent Care)	
FIP	NIP	5.4	-	Patients educated on after hours care	
FIP	NIP	5.5	-	12 after hours available	
FIP	NIP	5.6	√	ADVANCED-Non ED after hours urgent care has access to EMR/Registry & documents DURING visit	
FIP	NIP	5.7	√	Advanced access scheduling for 30% of daily appointments; SCP tiered access in place **Documented Process Required**	
FIP	NIP	5.8	√	Advanced access scheduling for 50% of daily appointments **(PCP Only)** **Documented Process Required**	
FIP	NIP	5.9	-	Interpreter service	
6.0 Test Tracking				Goal: To implement a standardized system to ensure patients receive needed test, and that results are communicated in a timely manner. As well as appropriate follow-up occurs. This process should be documents and all staff trained on it.	
FIP	NIP	6.1	√	Practice has a test tracking process/procedure which includes time frames for notification **Documented Process Required**	

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Alnitiative			Demo	Description	Notes:
FIP	NIP	6.2	√	Systematic approach to ensure time frames for patient notifications is met & ensure test performed	
FIP	NIP	6.3	√	Update patient contact information	
FIP	NIP	6.4	√	Mechanism in place to inform of normal test results	
FIP	NIP	6.5	√	Mechanism to inform of abnormal results	
FIP	NIP	6.6	√	Systematic approach to ensure follow up for abnormal results	
FIP	NIP	6.7	√	Systematic approach for documentation of test tracking steps in medical record	
FIP	NIP	6.8	√	Staff training on test tracking **Documentation Required**	
FIP	NIP	6.9	√	ADVANCED-CPOE with automated test tracking system	
8.0 e-Rx				**Goal:** Increase the use e-Rx to element Rx errors and duplications.	
FIP	NIP	8.7	-	Full e-Rx functionality by ALL PCPs	
9.0 Preventive Services				**Goal:** Coordinate patient care through the PCP in a PCMH that involves actively counseling, screening and educating patients on preventive care.	
FIP	NIP	9.1	-	Patient questionnaire about personal health behavior. i.e. patient check-in /demographic forms	
FIP	NIP	9.2	-	Preventive care guidelines in use	
FIP	NIP	9.3	√	Outreach reminders- Birthday, annual physicals, imms, well visits	
FIP	NIP	9.4	-	Inquires about outside health encounters- update patient chart history w/dates of services	
FIP	NIP	9.5	√	Smoking cessation	
FIP	NIP	9.6	√	Written standing order protocols for preventive services **Documentation Required**	
FIP	NIP	9.7	√	Secondary prevention screening	
FIP	NIP	9.8	√	Staff receives training/updates on preventive practices	
FIP	NIP	9.9	√	Planned visits for preventive services **Documented Process Required**	
10.0 Linkage to Community Services				**Goal:** To connect patients with community resources through a process of active coordination between the patient, health system, community service agencies, caregivers and family.	
FIP	NIP	10.1	√	PO has conducted comprehensive review of resources available in geographic area	

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FIP	NIP	10.2	√	PO maintains a community resource database	
FIP	NIP	10.3	√	PO /PU has relationship w/community agency(s)	
FIP	NIP	10.4	√	All team members educated & empowered to refer	
FIP	NIP	10.5	√	Systematic approach to educate patients and families about resources and referral	
FIP	NIP	10.6	√	Systematic referral process to community services	
FIP	NIP	10.7	√	Systematic referral tracking for high risk	
FIP	NIP	10.8	√	Systematic process for follow up w/high risk patients regarding next steps	
11.0 Self Management Support				**Goal:** To support the patient as they learn to assume responsibility for daily management of their chronic condition. Systematic approach to empowering patient to understand and manage chronic illness make informed decisions about care and engaging in healthy behaviors.	
FIP	NIP	11.1	√	Clinical Team member/PO staffperson is educated on self mgmt techniques. **(Must be in place before 11.2-11.7)**	
FIP	NIP	11.2	√	Self mgmt support, 1 chronic condition	
FIP	NIP	11.3	√	Systematic follow up on goals, for 1 chronic condition- reach out between visits	
FIP	NIP	11.4	√	Patient surveys for those involved in self mgmt; Results quantified, aggregated, and tracked over time	
FIP	NIP	11.5	√	Self management offered to all patients	
FIP	NIP	11.6	√	Systematic follow up on goals, for all conditions- reach out between visits	
FIP	NIP	11.7	√	Support and guidance offered to ALL patients working on self management goal	
FIP	NIP	11.8	√	Formally trained PO/PU member through national or inter-national accredited program	
12.0 Web Portal				**Goal:** To support optimal management of patients with chronic conditions by using a web portal to allow for electronic communication between patients and physicians, to provide greater access to medical information and technical tools.	
FIP	NIP	12.1	-	Vendor options for purchase have been evaluated	
FIP	NIP	12.2	-	PO assessed liability & safety issues for portal maintenance	
FIP	NIP	12.3	√	Patients can request appointments electronically	
FIP	NIP	12.4	√	Patients can log/graph self administered tests	

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FIP	NIP	12.5	√	Provider receives auto alert that potential health issue information has been logged	
FIP	NIP	12.6	√	Patients can participate in E-visits	
FIP	NIP	12.7	√	Automated care reminders (preventive services), self mgmt & health education material, resource links, & educational websites available electronically	
FIP	NIP	12.8	√	Patient can create personal health record	
FIP	NIP	12.9	√	Test results can be viewed on portal	
FIP	NIP	12.10	√	Patient can request Rx renewal	
FIP	NIP	12.11	√	Patients can graph /analyze self administered tests for self management purposes	
FIP	NIP	12.12	√	EMR available online	
FIP	NIP	12.13	√	Patients can schedule appointments electronically	
13.0 Coordination of Care				**Goal:** For patient care to be coordinated across the health system through a process of active collaboration and communication between providers, caregivers and the patient.	
FIP	NIP	13.1	√	Notification of admit/discharge or other health encounter for 1 chronic condition.	
FIP	NIP	13.2	√	Information exchange process - transfer of care to other providers/facilities.	
FIP	NIP	13.3	√	Tracking process for care coordination for 1 chronic condition	
FIP	NIP	13.4	√	Process to flag for immediate attn any urgent follow up for 1 chronic condition	
FIP	NIP	13.5	√	Written transition plans for patients leaving practice **Documentation Required**	
FIP	NIP	13.6	√	Process for case management coordination BCN 800-392-2512 BCBSM 800-845-5982	
FIP	NIP	13.7	√	Written procedure or guideline for care coordination process with clearly defined roles (i.e. Home care, rehab, acute hospital) **Documented Process Required**	
FIP	NIP	13.8	√	Care coordination in place for all patients w/chronic conditions **Must have 13.7 FIP before 13.8 or 13.9**	
FIP	NIP	13.9	√	Care coordination in place for ALL patients	
FIP	NIP	13.10	√	Hospital discharge follow-up within 24-48hrs **Documentation Required**	

AInitiative			Demo	Description	Notes:
14.0 Specialist Referral Process				**Goal:** Ensure the process of referring patients from primary care to specialty care is seamlessly coordinated; both providers receive timely access to the information needed to provide optimal care.	
FIP	NIP	14.1	√	Documented procedures in place to guide specialist referral include time frames for appt & information exchange for high volume providers **Documented Process Required**	
FIP	NIP	14.2	√	Documented procedures in place to guide specialist referral include time frames for appt & information exchange for other key providers **Documented Process Required**	
FIP	NIP	14.3	√	Specialist directory is available & maintained	
FIP	NIP	14.4	√	Specialist referral material supportive of process and individual patient needs	
FIP	NIP	14.5	-	Appointments are made for patients	
FIP	NIP	14.6	√	Each facet of interaction with SCPs & PCPs is automated using electronic tools (EHR/Registry)	
FIP	NIP	14.7	√	Referral tracking process	
FIP	NIP	14.8	-	Staff trained on referral process	
FIP	NIP	14.9	√	Patient satisfaction assessed and followed up for specialist care; Results quantified, aggregated, and tracked over time	
FIP	NIP	14.10	√	Physician-to-physician pre-consultation exchanges. **Documented Process Required**	