PCMH-A EXAMPLES TOOL

INTRODUCTION:

The goal of the Safety Net Medical Home Initiative (SNMHI) is to support health centers in implementing and sustaining the Patient-Centered Medical Home (PMCH) model. One way to measure the degree to which teams have implemented the PMCH is the Patient-Centered Medical Home Assessment, or PCMH-A. All participating SNMHI sites have been completing this tool twice per year throughout the Initiative. In the Pittsburgh region, and across the other four regions participating in the SNMHI, the impressive work of health center teams in transforming their practices has resulted in steadily improving PCMH-A scores. It is the goal of the SNMHI for all participating sites to achieve overall PCMH-A scores in the Levels B and A ranges, which equates to overall scores between 7 and 12 points.

As your team completes the PCMH-A, consider the many improvements you have made over the past several years as you've been working to implement the PCMH model. To add clarity to the criteria for achieving Levels B and A, the PRHI coaching team has assembled examples of activities consistent with Levels B and A performance from Pittsburgh health centers and from health centers in other regions. Please refer to these examples as you complete the PCMH-A, and reflect on the changes you have implemented in your practice. This is not an exhaustive list, so please do not feel like the examples listed are the only ones that would qualify you for a score. They are for your reference and to help you understand what kind of work is being looked at for each section.

This tool is an initial effort to help clarify the PCMH-A. If you have questions, feedback or would like further examples, please ask your coach.

EMPANELMENT:

GOAL

Components	Level D	Level C	Level B	Level A
1. Patients	...are not assigned to specific practice panels.	...are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes.	...are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes.	...are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Level B:

The team has reviewed and revised its patient lists, ensuring that all patients are assigned to a provider at the practice or appropriately identified as belonging to another practice. If a patient calls to schedule an appointment, the registration staff first tries to schedule patients with the assigned PCP, though exceptions are made. Effective use of the panels includes providing business cards to patients with the names of their care team members, referring phone calls to appropriate care team members, and indicating care team members on brochures and correspondence.

Level A:

In addition to the above: As patients arrive for appointments, registration staff review the patient's panel assignment. If the PCP has changed, the staff reviews past appointments and reassigns the patient. Appointment reports are periodically reviewed to ensure continuity of care for patients. The practice is running panel level reports to manage supply and demand on each provider's schedule.

GOAL

2. Registry or panel-level data	...are not available to assess or manage care for practice populations.	...are available to assess and manage care for practice populations, but only on an ad hoc basis.	...are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states.	...are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Level B:

The practice obtains two or three registry (or panel) reports on a regular basis (at least quarterly) that are used for managing care of the population. Reports are shared with care team members. In sites closer to a 9, these reports are reviewed by the team for opportunities to improve care and are also used to monitor progress on other interventions. Targeted populations might include patients with poor diabetes or hypertension control, patients seen in the ER, or other patients with chronic disease who have not returned for care.

Level A:

In addition to the above: Reports is available for multiple disease states or patient groups. These should be available across the practice for diseases considered important by the care teams. Flexibility in pulling different reports when needed is also an asset to achieve higher scores. Not only are data for an array of patient populations routinely available to care teams, the data are acted upon consistently by care teams.

				GOAL	
3. Registries on individual patients	...are not available to practice teams for pre-visit planning or patient outreach.	...are available to practice teams but are not routinely used for pre-visit planning or patient outreach.	...are available to practice teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states.	...are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Level B:

Practice pulls and uses data from registries (or EHR) weekly/daily on individual patients in order to conduct pre-visit planning, as well as to reach out to patients regarding overdue services, certain clinical values (lab results, etc.), visit needs, etc. This information may only be available for certain disease or risk states, like diabetes, hypertension, and depression, etc.

Level A:

In addition to the above: information is available for patients on a more comprehensive set of disease and risk states. The use of data for pre-visit planning and outreach extends beyond a limited scope of disease states, and extends to multiple aspects of patient care (e.g. preventive services, chronic care services, upcoming and past-due services, etc.).

			GOAL	
4. Reports on care processes or outcomes of care	...are not routinely available to practice teams.	...are routinely provided as feedback to practice teams but not reported externally.	...are routinely provided as feedback to practice teams, and reported externally (e.g. to patients, other teams or external agencies) but with team identities masked.	...are routinely provided as feedback to practice teams, and transparently reported externally to patients, other teams and external agencies.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Level B:
The practice runs reports on process and/or outcomes measures and shares those reports routinely with teams, at least once per quarter. Practice displays or disseminates data, but keeps identities of providers and teams blinded. Data could be displayed on a data board or shared with peer groups or on practice's website.

Level A:
Same as above; however, the site shares team identified data with each other and with patients, health plans, government agencies and other entities. This could include data posted on data boards or on websites with team names displayed with the data.

CONTINUOUS TEAM-BASED HEALING RELATIONSHIPS

GOAL

Components	Level D	Level C	Level B	Level A
5. Patients are encouraged to see their paneled provider and practice team	...only at the patient's request.	...by the practice team, but is not a priority in appointment scheduling.	...by the practice team and is a priority in appointment scheduling, but patients commonly see other providers because of limited availability or other issues.	...by the practice team, is a priority in appointment scheduling, and patients usually see their own provider or practice team.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Level B:
Front office/triage reviews "add-ons" with care teams before scheduling, and schedules with another provider only if there is not an opportunity to schedule with the practice team.

Level A:
In addition to the above: Each provider and care team has daily "open access" appointments into which patients may be scheduled. Priority for the open access appointments is given to patients empaneled with the provider or care team. Every effort is made to schedule the patient with their paneled provider.

GOAL

6. Non-physician practice team members	...play a limited role in providing clinical care.	...are primarily tasked with managing patient flow and triage	...provide some clinical services such as assessment or self management support.	...perform key clinical service roles that match their abilities and credentials.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Level B:
Medical Assistants or nurses participate in medication reconciliation, or assess smoking behavior, or administer screening tests, or elicit reason for visit, etc..

Level A:
In addition to the above: Medical Assistant or nurses provide formal patient education, or provide special assessments and treatments allowed by licensure and training, such as spirometry, lab testing, counseling and referral..

							GOAL					
7. The practice	...does not have an organized approach to identify or meet the training needs for providers and other staff.			...routinely assesses training needs and assures that staff are appropriately trained for their roles and responsibilities.			...routinely assesses training needs, assures that staff are appropriately trained for their roles and responsibilities, and provides some cross training to permit staffing flexibility.			...routinely assesses training needs, assures that staff are appropriately trained for their roles and responsibilities, and provides cross training to assure that patient needs are consistently met.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

Level B:
Training needs of staff are reviewed by managers/directors on a semi-annual basis, and time is set aside for staff to dedicate to training within work hours. Cross training occurs for those who are interested and/or find the time to train.

Level A:
Training needs for all staff are reviewed by managers/directors on a quarterly basis, and a budget for training is made available by executive and board/level leadership. Ongoing training and cross-training is expected, incorporated into annual performance evaluations, and time is carved out within working hours for staff to complete training.

PATIENT-CENTERED INTERACTIONS

Components	Level D	Level C	GOAL Level B	Level A
8. Assessing patient and family values and preferences	...is not done.	...is done, but not used in planning and organizing care.	...is done and providers incorporate it in planning and organizing care on an ad hoc basis.	...is systematically done and incorporated in planning and organizing care.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Level B:

Providers add information about family values and preferences to care plans as the provider sees fit. Data about values and preference are entered as free text in the EHR visit note.

Level A:

Providers and other care team members routinely capture and review family values and preferences (e.g. preferred language, religion/spiritual beliefs), record them in structured data fields in the EHR, and incorporate into care plans.

			GOAL	
9. Involving patients in decision-making and care	...is not a priority.	...is accomplished by provision of patient education materials or referrals to classes.	...is supported and documented by practice teams.	...is systematically supported by practice teams trained in decision making techniques.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Level B:

Structured data fields are available in the EHR to document self-management goals and patient decisions. Providers and care team members complete these fields at their discretion when they see fit.

Level A:

Structured data fields are available in the EHR to document goals and patients' decisions regarding their care, and these fields are consistently used by all providers.

			GOAL	
10. Patient comprehension of verbal and written materials	...is not assessed.	...is assessed and accomplished by assuring that materials are at a level and language that patients understand.	...is assessed and accomplished by hiring multi-lingual staff, and assuring that both materials and communications are at a level and language that patients understand.	...is supported at an organizational level by translation services, hiring multi-lingual staff, and training staff in health literacy and communication techniques (such as closing the loop) assuring that patients know what to do to manage conditions at home.

Level B:

When necessitated by the needs of the patient population, the practice hires multi-lingual staff and ensures these staff members are available so that care may be delivered in the patient's preferred language. For example, sites with a sizeable number of Spanish-speaking patients hire staff who are proficient in speaking Spanish. For those practices that do not have sizeable numbers of patients who speak a language other than English as their primary language, it may not be necessary to hire multilingual staff. However, the language needs of the population are routinely assessed and language support services (e.g. Language Line, translators from the community) are consistently available.

Level A:

Level B activities, plus staff are all trained in health literacy and methods (e.g. "teach back" method) to ensure patients understand their care plans and patient education materials. Patient education materials are translated into the preferred language of the patient. An example is that one site made arrangements with a local University to translate common patient education materials and office forms into Spanish.

			GOAL	
11. Self-management support	...is limited to the distribution of information (pamphlets, booklets).	...is accomplished by referral to self-management classes or educators.	...is provided by goal setting and action planning with members of the practice team.	...is provided by members of the practice team trained in patient empowerment and problem-solving methodologies.

Level B:

Self-management goals are routinely discussed with patients, and goals are consistently documented in the care plan within the EHR.

Level A:

Providers and other care team members are trained in motivational interviewing and routinely use this approach to engage patients in identifying and working towards achieving self-management goals. Another example is that peer wellness coaches use the "Personal Medicine" framework to identify self-management goals and preferences with patients.

			GOAL	
12. The principles of patient-centered care	...are included in the organization's vision and mission statement.	...are a key organizational priority and included in training and orientation.	...are explicit in job descriptions and performance metrics for all staff.	...are consistently used to guide organizational changes and measure system performance as well as care interactions at the practice level.

Level B:

Patient experience surveys are conducted on at least a quarterly basis, and results are shared at the care-team level. The care teams are expected to review the patient experience data and implement improvements related to the metrics. Time is carved out once per month from an all-staff meeting for teams to work on identifying and implementing improvements. Job descriptions explicitly outline this responsibility.

Level A:

Results of patient experience surveys are analyzed not only at the care team level, but also by practice leadership and the board of directors. These data are used to guide decisions about process improvement and the allocation of resources to improvement efforts.

ENGAGED LEADERSHIP

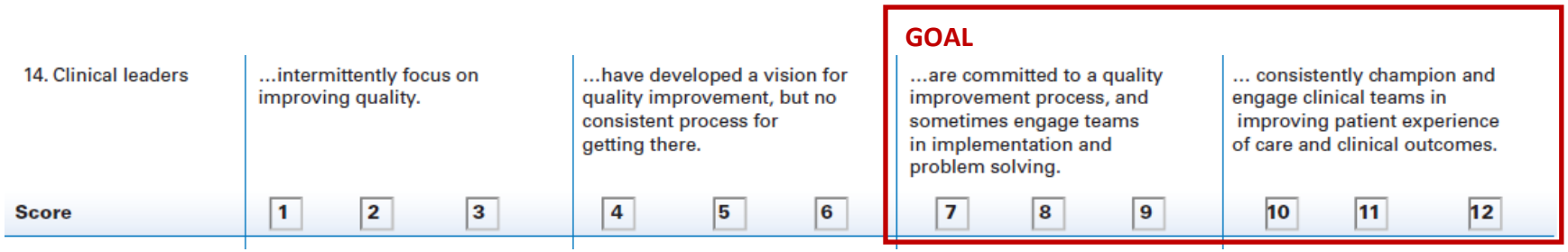
				GOAL	
Components	**Level D**	**Level C**		**Level B**	**Level A**
13. Executive leaders	...are focused on short-term business priorities.	...visibly support and create an infrastructure for quality improvement, but do not commit resources.		...allocate resources and actively reward quality improvement initiatives.	...support continuous learning throughout the organization, review and act upon quality data, and have a long-term strategy and funding commitment to explore, implement and spread quality improvement initiatives.
Score	1 2 3	4 5 6		7 8 9	10 11 12

Level B:

Senior leadership routinely evaluates quality improvement (QI) opportunities and works collaboratively with a Quality Improvement Committee to prioritize improvements and ensure that resources (e.g. personnel, financial) are available to support teams in implementing the improvements. Leaders routinely review the results of the improvement efforts and reward teams for their improvement efforts such as providing personal notes to staff members or a small token (e.g. lunch) when improvement teams meet or exceed their identified goals.

Level A:

Leadership supports continuous learning by circulating important QI articles and materials, providing journal subscriptions, and providing conference subsidies. Leadership participates in identifying and implementing Plan-Do-Study-Act cycles based upon performance metrics (e.g. clinical outcomes, patient experience surveys). Leadership offers prompt and specific responses to identified quality issues. Leadership includes QI in mission statement, organizational chart, job descriptions, and budget line items. Participate in federal, state and health plan pay-for-performance programs. Invest in staff and facilities that allow fiscally-sound innovation. Support realistic timelines for QI initiatives, and acknowledge the need to learn from initial failures.



Level B:

The clinical leader (e.g. Medical Director) is an active participant of a QI committee that meets monthly. The leader communicates outcomes of the QI meetings to the rest of the clinical team, and occasionally leads teams in identifying improvement opportunities and implementing an improvement (e.g. a PDSA cycle).

Level A:

The clinical leader mentors others in QI by consistently using QI methodologies (e.g. PDSA cycles) himself/herself. The medical director mentions QI activities regularly In staff newsletters, management reports, staff meetings, and includes QI in agenda of planning and operations meetings. The medical director includes QI team representatives in senior staff meetings and consults QI teams about changes in staffing, facilities, work responsibilities, and funding. The medical director or clinical lead specifically responds to all QI team reports and recommendations.

							GOAL					
15. The organization's hiring and training processes	...focus only on the narrowly defined functions and requirements of each position.			...reflect how potential hires will affect the culture and participate in quality improvement activities.			...place a priority on the ability of new and existing staff to improve care and create a patient-centered culture.			...support and sustain improvements in care through training and incentives focused on rewarding patient-centered care.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

Level B:

Job descriptions include requirements for training and experience in quality improvement and/or in motivational interviewing and use of EHRs. Job descriptions outline responsibility for continuous improvement within their role.

Level A:

Training opportunities are publicized throughout the practice, and funding (e.g. reimbursement for training fees) is made available to staff and providers. Patient engagement, patient and staff satisfaction, process efficiency and clinical quality indices are used to measure care team performance. Data are publicized via monthly dashboards and recognition is given for excellence in QI (e.g. small reward, team lunch).

							GOAL					
16. The responsibility for conducting quality improvement activities	...is not assigned by leadership to any specific group.			...is assigned to a group without committed resources.			...is assigned to an organized quality improvement group who receive dedicated resources.			...is shared by all staff, from leadership to team members, and is made explicit through protected time to meet and specific resources to engage in QI.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

Level B:

The QI committee is given protected time four hours per month to review progress towards QI goals and prioritize future QI activities. These hours are during regular working hours, and adjustments are made to productivity expectations for clinicians participating on the QI committee.

Level A:

Two hours once per month at an all-staff meeting are carved out for care teams to review their data and identify improvement opportunities and design improvement activities. Participation is expected by all staff, including leadership, clinical and frontline. Participation of leadership and staff in QI activities is evaluated as part of employee performance reviews. Leadership provides access to resources for QI activities, including meeting space, meeting equipment and materials, training and enrichment opportunities (e.g. Safety Net Medical Home Initiative learning sessions), content experts, data analysis.

QUALITY IMPROVEMENT STRATEGY

Components	Level D	Level C	GOAL Level B	Level A
17. Quality improvement activities	...are not organized or supported consistently.	...are conducted on an ad hoc basis in reaction to specific problems.	...are based on a proven improvement strategy in reaction to specific problems.	...are based on a proven improvement strategy and used continuously in meeting organizational goals.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Level B:

The practice uses a specific improvement methodology (e.g. Perfecting Patient Care/Lean, PDSA) to analyze and address specific problems (e.g. a spike in wait times that fails to meet the practice's standards). The practice provides a forum for patients and families to share issues for improvement (e.g. point-of-care surveys, suggestion box located in the lobby).

Level A:

All improvement opportunities, whether they are of a clinical, frontline, or leadership nature, are addressed using a common QI approach. Patients and families are routinely offered the opportunity to provide feedback re: quality improvement opportunities, and there is a process by which the patient/family is given feedback re: the status and outcome of improvement efforts.

			GOAL	
18. Performance measures	...are not available for the clinical site.	...are available for the clinical site, but are limited in scope.	...are comprehensive – including clinical, operational, and patient experience measures – and available for the practice, but not for individual providers.	...are comprehensive – including clinical, operational, and patient experience measures – and fed back to individual providers.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Level B:

Monthly metrics are posted on a bulletin board, in a staff newsletter (one site posts these newsletters in staff restrooms for "bathroom reading!") so that all staff have access to up-to-date information about performance metrics. Quarterly SNMHI reports are shared with all staff and posted in a location convenient for staff to review. Time is carved out at all-staff meeting to discuss the report and identify improvement opportunities and an action plan.

Level A:

Same as above, *and* data are provided at the provider level. For example, one site provides monthly "data dashboards" to each provider that includes key process and outcomes measures, as well as performance on Meaningful Use measures. Data are un-blinded so that providers may transparently see how their data compares with that of other providers.

GOAL

19. Quality improvement activities are conducted by	...a centralized committee or department.			...topic specific QI committees.			...all practice teams supported by a QI infrastructure.			...practice teams supported by a QI infrastructure with meaningful involvement of patients and families.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

Level B:

Staff are provided with tools to support problem solving activities, such as a "problem solving template" and Tomorrow's HealthCare, PRHI's web-based QI portal. Staff utilized QI resources, such as practice coaches available through PRHI/SNMHI, for support in designing and implementing QI activities.

Level A:

Patient/family representatives participate in QI committee meetings. Patient/family focus groups are conducted around specific improvement opportunities (e.g. telephone and face-to-face access to the care team), and feedback is incorporated into the design of improvements.

ENHANCED ACCESS

GOAL

Components	Level D			Level C			Level B			Level A		
20. Appointment systems	...are limited to a single office visit type.			...provide some flexibility in scheduling different visit lengths.			... provide flexibility and include capacity for same day visits.			...are flexible and can accommodate customized visit lengths, same day visits, scheduled follow-up and multiple provider visits.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

Level B:

Practice may reserve appointment slots for same day appointments within the scheduling system, and scheduling staff are able to double book and reserve longer appointments for longer visits. Patients may or may not be able to get other appointments at the time requested.

Level A:

All of above, *and* practice has implemented an open access or modified open access system with flexibility in the schedule. Staff may have the ability to change the length of appointment times to meet patient needs. In sites more advanced with the change concept, patients can schedule visits with multiple providers, schedule follow up visits or same day visits.

							GOAL					
21. Contacting the practice team during regular business hours	...is difficult.			...relies on the practice's ability to respond to telephone messages.			...is accomplished by staff responding by telephone within the same day.			...is accomplished by providing a patient a choice between email and phone interaction, utilizing systems which are monitored for timeliness.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

Level B:

Messages (via phone or email) are answered within the same day by the practice team. Practices doing well with this model often return calls within the same session, or within 2 hours of the call, and have a clearly defined standard for when and by whom calls will be returned.

Level A:

All of the above, *and* practice has a secure email messaging system (or portal) that patients can use for questions and/or scheduling. The email is checked regularly for messages, similar to phone message systems, and returned through proper channels (email with email, call with call). In advanced practices, the follow up time for both mechanisms is clearly defined and is monitored to ensure appropriate timeliness.

				GOAL		
22. After hours access	...is not available or limited to an answering machine.		...is available from a coverage arrangement without a standardized communication protocol back to the practice for urgent problems.		...is provided by coverage arrangement that shares necessary patient data and provides a summary to the practice.	...is available via the patient's choice of email, phone or in-person directly from the practice team or a provider closely in contact with the team and patient information.
Score	1 2 3		4 5 6		7 8 9	10 11 12

Level B:

After hours coverage is provided by an o- call physician or provider that has the ability to provide a timely summary of activities to the practice. This could be sharing an EHR or faxing reports, etc. A standardized process for communicating is in place. Providers giving coverage have access to necessary patient information (via the practice's EHR or a phone call with a member of the patient's care team) for accurate treatment.

Level A:

The patient has multiple options for how to contact the practice for after-hours service, which include email, telephone or in-person contact. The practice may have arrangements with other physicians within the community or urgent care centers that have access to the necessary patient information. The practice may also hold appointment times in the evenings or on weekends. When coverage is provided by an external provider (e.g. emergency room physician), that provider has access to the care team via telephone for discussion of important information and care planning.

				GOAL		
23. A patient's insurance coverage issues	...are the responsibility of the patient to resolve.		..are addressed by the practice's billing department.		...are discussed with the patient prior to or during the visit.	...are viewed as a shared responsibility for the patient and an assigned member of the practice to resolve together.
Score	1 2 3		4 5 6		7 8 9	10 11 12

Level B:

Practice acknowledges the need to address insurance issues with patients to help meet their health care needs. Someone at the practice discusses insurance coverage with the patient either via phone or at the visit with some consistency. This could be the registration representative, nurse, provider or other member of the team. Practice may or may not assist the patient with filling their needs.

Level A:

All of the above, *and* the practice has designated a role for someone in the office to work with patients on fulfilling their insurance needs such as a financial counselor or a designated member of the care team (e.g. social worker, care manager). The practice takes on some responsibility for helping the patient work through their insurance coverage issues (sliding fee, assisting with financial assistance applications, etc.)

CARE COORDINATION

GOAL

Components	Level D	Level C	Level B	Level A
24. Medical and surgical specialty services	...are difficult to obtain reliably.	...are available from community specialists but are neither timely nor convenient.	.... are available from community specialists and are generally timely and convenient.	...are readily available from specialists who are members of the care team or who work in an organization with which the practice has a referral protocol or agreement.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Level B:

The practice has made arrangements with specialists (e.g. dentists) who have agreed to see the practice's patients. There may be a formal arrangement between the practice and specialists (e.g. the specialist agrees to reserve 4 slots per month specifically for the practice's patients), or an informal yet reliable relationship. Patients are provided the name and contact information for the specialist and assistance with scheduling is provided, when needed, by a care team member.

Level A:

A variety of specialty services (e.g. dental, behavioral health, ob/gyn) are offered on-site at the practice. For those services that are not available on site, the practice has clearly defined relationships with specialists, and, in some cases, contractual relationships for the provision of specialty services. The referral and feedback processes are clearly defined. One site has a relationship with a community ophthalmologist who completes retinal eye screenings for diabetic patients remotely, with results fed directly into the practice's EHR.

			GOAL	
25. Behavioral health services	...are difficult to obtain reliably.	...are available from mental health specialists but are neither timely nor convenient.	...are available from community specialists and are generally timely and convenient.	...are readily available from behavior health specialists who are onsite members of the care team or who work in a community organization with which the practice has a referral protocol or agreement.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Level B:

The practice is knowledgeable about community behavioral health resources located nearby the practice and in the communities of the patients served. Referrals to behavioral health specialists are made with consideration of the patient's behavioral health needs, location of services, insurance coverage/payment options, and timely accessibility of services.

Level A:

The practice has a social worker, therapist, or behavioral health consultant on site, and the care team routinely ensures a "warm hand-off" from the provider to the behavioral health specialist. Several practices contract with or have regular access to a consulting psychiatrist who is available to provide support to the care team re: treatment planning and complex patients.

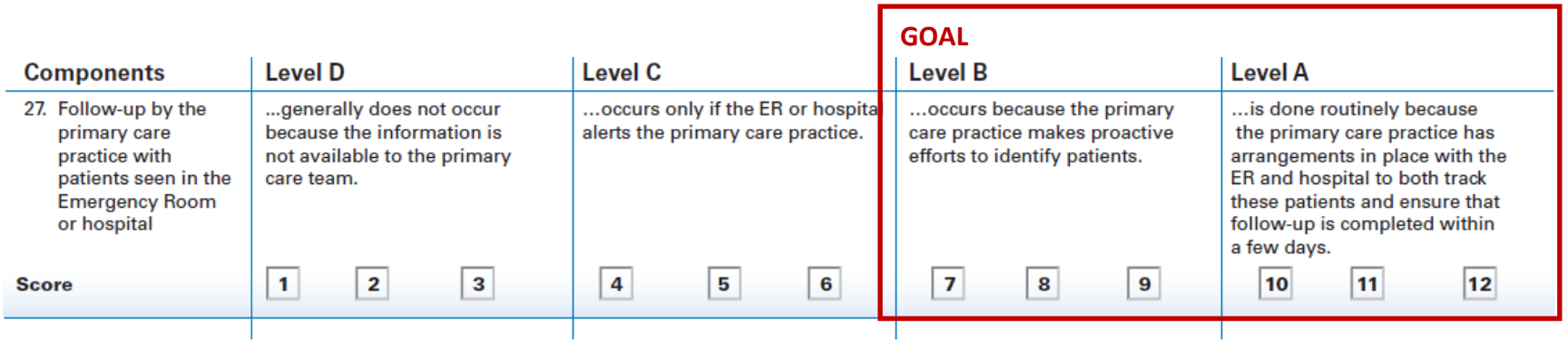
			GOAL	
26. Patients in need of specialty care, hospital care, or supportive community-based resources	...cannot reliably obtain needed referrals to partners with whom the practice has a relationship.	...obtain needed referrals to partners with whom the practice has a relationship.	...obtain needed referrals to partners with whom the practice has a relationship and relevant information is communicated in advance.	...obtain needed referrals to partners with whom the practice has a relationship, relevant information is communicated in advance, and timely follow-up after the visit occurs.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Level B:

The practice has an up-to-date list of specialists and hospitals willing and able to serve the practice's patients, including those who are un- or under-insured. The practice facilitates referrals to the providers and community resources, and provides relevant patient history and referral information prior to the appointment.

Level A:

Same as above, *and* the practice uses a referral tracking system built into the EHR to monitor the status of referrals. A care team member follows up with patients and community specialists when referrals are not completed in the expected time frame, and assists in trouble shooting barriers to completing the referral.



Level B:

The practice worked with the hospital to which it refers the majority of its patients to identify a process by which patients visiting the ER are routinely identified. ER discharge and hospital admissions reports are consistently faxed by the hospital to the practice. The practice reminds patients as part of its new patient orientation and patient handbook of the importance of letting the care team know of any visits to the ER in a timely fashion, to ensure appropriate follow up. Patients are also reminded to clearly identify the PCP and practice upon registration at the hospital to ensure communication between the hospital and practice.

Level A:

An electronic notification (via email) of a patient's visit to the ER is given by the hospital to the provider. Providers have access to the hospital's EHR system to review ER discharge reports.

28. Linking patients to supportive community-based resources	...is not done systematically.			...is limited to providing patients a list of identified community resources in an accessible format.			GOAL ...is accomplished through a designated staff person or resource responsible for connecting patients with community resources.			...is accomplished through active coordination between the health system, community service agencies and patients and accomplished by a designated staff person.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

Level B:

Care team members refer patients to the care manager or social worker for assistance in connecting with community resources.

Level A:

The care manager, social worker, or another member of the care team assists the patient with scheduling appointments and ensuring that all necessary information from the practice is communicated to the community provider/agency in a timely manner.

29. Test results and care plans	...are not communicated to patients.			...are communicated to patients based on an ad hoc approach.			GOAL ...are systematically communicated to patients in a way that is convenient to the practice.			...are systematically communicated to patients in a variety ways that are convenient to patients.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

Level B:

The practice has a clearly defined process by which test results are communicated to patients (i.e. when and by whom test results should be communicated to patients). Results are typically provided via telephone or mail (for normal results).

Level A:

Same as above, *and* patients are asked their preference for the way in which results are communicated (e.g. secure email, telephone call, letter, text message). When appropriate, the patient preference for communication method is followed by the practice.

ORGANIZED EVIDENCE-BASED CARE

Components	Level D	Level C	GOAL Level B	Level A
30. Comprehensive, guideline-based information on prevention or chronic illness treatment	...is not readily available in practice.	...is available but does not influence care.	...is available to the team and is integrated into care protocols and/or reminders.	...guides the creation of tailored, individual-level data that is available at the time of the visit.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Level B:

The practice uses structured templates and decision support tools (e.g. health maintenance alerts, drug-drug interaction alerts) available in the EHR. The templates are modified or customized, as needed, when guidelines are updated.

Level A:

Guidelines are clearly communicated as part of patient education and self-management support (e.g. diabetes management "fact sheets" are made available to patients), and are routinely considered when developing self-management goals and care plans with patients.

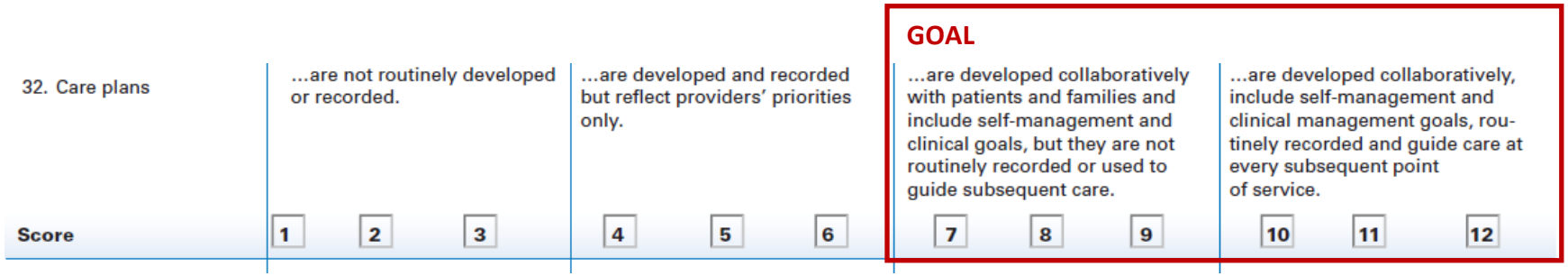
			GOAL	
31. Visits	...largely focus on acute problems of patient.	...are organized around acute problems but with attention to ongoing illness and prevention needs if time permits.	...are organized around acute problems but with attention to ongoing illness and prevention needs if time permits. The practice also uses subpopulation reports to proactively call groups of patients in for planned care visits.	...are organized to address both acute and planned care needs. Tailored guideline-based information is used in team huddles to ensure all outstanding patient needs are met at each encounter.
Score	1 2 3	4 5 6	7 8 9	10 11 12

Level B:

Health maintenance (e.g. preventative screenings, immunizations) is reviewed as part of a routine diabetes visits, as time permits. The care team's Medical Assistant contacts diabetic patients in need of HbA1c prior to their planned visit to ensure that the results of the HbA1c are available to the provider and patient at the time of the visit to guide care planning.

Level A:

Acute care visits are scheduled for the same amount of time as planned care visits (20 minutes) to allow time for review of prevention and ongoing chronic disease management needs as part of acute care visits. Team huddles occur daily for both planned and acute care visits, and anticipated needs (e.g. preventative screenings, immunizations, referral to community resources) are identified and tasks assigned to the care team members to review with the patient at the time of the visit.



Level B:

A care plan is established with all diabetic patients that includes self-management goals and recommendations for diet, exercise and medication management. This care plan is completed via paper format and given to the patient, but not documented in the practice's EHR.

Level A:

Self-management goals are consistently documented by all providers in the EHR, and progress towards goals is routinely reviewed and documented at subsequent visits. Barriers to progress are identified, and the care team offers support to the patient in overcoming barriers and/or revising goals.

							GOAL					
33. Clinical care management services for high risk patients	...are not available.			...are provided by external care managers with limited connection to practice.			...are provided by external care managers who regularly communicate with the care team.			...are systematically provided by the care manager functioning as a member of the practice team, regardless of location.		
Score	1	2	3	4	5	6	7	8	9	10	11	12

Level B:

The practice works closely with care managers available through the patient's insurance company by providing necessary patient information and requesting regular follow-up by the care manager.

Level A:

The practice has an assigned care manager who routinely participates in care team reviews of patients. The care member is employed directly by the practice, and a system is in place to reliably idenfity the highest risk patients in need of care management support.