



PATIENT CENTERED HEALTH CARE HOME EDUCATION AND EVALUATION PROGRAM

HEALTH CARE PRACTICE ASSESSMENT TOOLKIT CHARACTERISTICS, Version 1.0

Note: This document contains 13 groups of Practice Design and Operational Characteristics, which relate to successful PCHCH assessment, development, implementation, operation, and maturation.

The PCHCH Education and Evaluation Program is an integrated series of three educational toolkits which can help guide individual practices, or their sponsoring health plans, insurers, state and federal health agencies, and/or pilot programs, through a step-wise journey towards becoming a fully engaged, operational, and effective PCHCH practice. The three Education and Evaluation Program Toolkits include:

- 1) **Health Care Practice Assessment Toolkit**
- 2) Patient Experience/Satisfaction Survey Toolkit
- 3) Performance Measurement Toolkit

The PCHCH Education and Evaluation Program's three toolkits are designed to complement each other, and can be used as stand-alone tools, or in any combination called for by practices and by sponsoring health care organizations. The PCHCH Education and Evaluation Program's three toolkits can be used by individual practices to assess their progress in building PCHCH capabilities, and be licensed to sponsoring health plans, insurers, health agencies, and pilot programs which can establish their own standards and benchmarks for evaluating participating practices' level of PCHCH advancement and eligibility for related incentives.

COMMENTERS' DIRECTIONS:

Please provide your comment/feedback on the PCHCH *Health Care Practice Assessment Toolkit* design and content. Be sure to select the appropriate Characteristic Group in the *Health Care Practice Assessment Toolkit* to submit your comment. Any general comments you have on the overall PCHCH Education and Evaluation Program's design and content, and not specific to the Practice Assessment Toolkit's Characteristics, should be provided in the "General Comments" section.

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PRACTICE SELF-ASSESSMENT AND THIRD PARTY ASSESSMENT OPTIONS: Helps practices and third party sponsoring organizations learn the essential characteristics of what constitutes a PCHCH, and provides a foundation for assessing a health care practice's current organization and infrastructure. This assessment allows a practice to begin and track the process of transforming itself into a PCHCH, through redesigning its infrastructure, policies, and workflows, providing targeted training to staff, effecting a major culture change that puts the patient first, and at the heart of all care decisions. The Practice Assessment Toolkit also allows a health care practice's progress towards becoming a fully functional PCHCH to be tracked and documented.

This toolkit can also be used as a basis for an external review agency, such as URAC, or a sponsoring third party organization, to independently validate a practice's readiness to be designated as a PCHCH, establish its eligibility for incentive funding, as well as for public reporting purposes, and marketing activities. Sponsoring organizations may choose to perform the external validation function with in-house staff, or choose to delegate this function to an external review agency such as URAC.

SUMMARY OF CONTENT FOR PUBLIC COMMENT:

The health care practice assessment toolkit contains 13 groups of practice design and operation Characteristics, which relate to successful PCHCH assessment, development and maturation. These Characteristic Groups include:

- 1) Partnership Agreement (PA)
- 2) Patient Registry (PR)
- 3) Access to Services (ATS)
- 4) Individual Care Management (ICM)
- 5) Test and Imaging Results (TIR)
- 6) Preventive Services (PS)
- 7) Community Services & Resources (CSR)
- 8) Self-Management Support (SMS)
- 9) Patient Web Portal (PWP)
- 10) Coordination of Care (COC)
- 11) Specialist Referral Process (SRP)
- 12) Performance Reporting (PRT)
- 13) PCHCH Organizational Core (COR)

PARTNERSHIP AGREEMENT (PA)**Characteristic PA-1: Partnership Agreement**

Practice Site has developed PCHCH-related patient communication tools, trained staff, and is prepared to implement patient-clinician partnership with each established patient, which may consist of a signed agreement or other documented patient communication process to establish patient-clinician partnership.

Characteristic PA-2: Partnership Outreach

Process of reaching out to established patients is underway and the Practice is using a systematic approach to inform patients about PCHCH, including patients who do not visit the Practice regularly.

Characteristic PA-3: Partnership Engagement

Practice fully explains the concept, advantages, and patient and team roles/responsibilities of a PCHCH model of care to its current and potential patients/families/caregivers and verify their understanding prior to executing Partnership Agreement.

Characteristic PA-4: Partnership Implementation

Patient-clinician agreement or other documented patient communication process is implemented and documented for at least:

- (a) 10% of current patients
- (b) 30% of current patients
- (c) 50% of current patients
- (d) 60% of current patients
- (e) 80% of current patients
- (f) 90% of current patients

PATIENT REGISTRY (PR)

Note: For all Patient Registry Characteristics, registry may be paper or electronic, except Characteristic PR-2 (Registry is Electronic). A fully electronic registry may be the last Characteristics to be implemented.

Characteristic PR-1: Registry Implementation

A paper or electronic all-payer registry is being used to manage all established patients in the Practice Site identified with high prevalence and/or high risk conditions.

Characteristic PR-2: Registry is Electronic

Registry is fully electronic.

Characteristic PR-3: Registry Clinician Attribution

Registry contains information on the individual attributed clinician for every patient currently in the registry who has a medical home in the Practice Site.

Characteristic PR-4: Registry Demographics and Clinical Parameters

Registry incorporates information on patient demographics and key clinical parameters for all patients currently in the registry to help ensure care needs and treatment are provided equitably based on clinical risk indicators.

Characteristic PR-5: Registry Clinical Information

Registry incorporates patient demographic and clinical information, preferably in an electronically searchable format, for all established patients in the registry, for a substantial majority of health care services received at other sites that are necessary to manage chronic care and preventive services for the population

Characteristic PR-6: Electronic Information Systems Used for Managing Patient Care

Practice utilizes an electronic system which has the following searchable elements:

- (a) Demographic Data and
- (b) Clinical data.

Characteristic PR-7: Registry Incorporates Guidelines and Team Approach

Registry incorporates evidence-based care guidelines and team approach.

Characteristic PR-8: Registry at Point of Care

Registry information is available and in use by the Practice Site team at the point of care.

Characteristic PR-9: Registry Used for Prevention

Registry incorporates preventive services guidelines and is being used to generate routine, systematic communication to all patients in the Practice regarding needed preventive services.

Characteristic PR-10: Registry Flags Gaps in Care

Registry is being used to flag gaps in care for every patient currently in the registry.

Characteristic PR-11: Registry Generated Communications

Registry is being used to generate routine, systematic communication to patients regarding gaps in care.

Characteristic PR-12: Registry of Non-Practice Patients

Registry incorporates patients who are assigned by managed care plans and are not established patients in the Practice.

ACCESS TO SERVICES (ATS)**Characteristic ATS-1: Patient Telephonic Access to Care**

Patients have 24-hour access to a licensed qualified health care professional by phone, requiring a feedback loop from this professional within 24 hours or next business day to the patient's PCHCH.

Characteristic ATS-2 Patient Information Available to Clinician

Patients have 24-hour access to licensed qualified health care professional (as defined in Characteristic ATS-Patient Telephonic Access to Care), which is enhanced by enabling this professional to access and update patient's EMR or registry information during the phone call.

Characteristic ATS-3 Patient Access to After-Hours Care

Clinician has made arrangements for patients to have access to non-emergency after-hours clinician for urgent care needs during at least 8 after-hours per week and, if different from the PCP office, after-hours licensed qualified health care professional has a feedback loop within 24 hours or next business day to the patient's PCHCH.

Characteristic ATS-4: Patient Information on After-Hours Care

A systematic approach is in place to ensure that all patients are fully informed about after-hours care availability and location, at the Practice, as well as other after-hours care sites, including urgent care facilities, if applicable.

Characteristic ATS-5: After-Hours Clinician Access to Patient Information

After-hours licensed qualified health care professional is enhanced by enabling non-emergency after-hours clinician for urgent care needs, including ability to prescribe medications, to access and update the patient's EMR or patient's registry record during the visit.

Characteristic ATS-6: Advanced Access Scheduling

Advanced access scheduling is in place reserving at least a certain percentage for same-day appointments (routine and acute care).

Characteristic AST-7: Enhancing Patient Access to Care

Practice uses the following processes to ensure a higher level of patient access and continuity of care:

- (a) Documents phone or email clinical advice in the patient record;
- (b) Provides copy of health information upon request;
- (c) Provides care plan summaries for patients/families at each office visit;
- (d) A process to assign patient/family to a personal clinician or team;
- (e) Maintains record of patient /family choice of clinician/team in the medical record;
- (f) Monitors proportion of patient visits that occur with assigned clinician/team;
- (g) Uses standing orders for routine medication refills, tests, routine preventive services; and
- (h) Care team staff assigned and trained in communication skills with vulnerable populations.

Characteristic AST-8: Ensure Equitable Access and Services

Practice has policies in place forbidding discrimination in access to care and provision of care services.

Characteristic AST-9: Ensure Appropriate Use of Clinical Guidelines

Practice has policies in place to track rates of provision for required services against clinical guidelines and take corrective measures, where indicated.

Characteristic ATS-10: Language Translators

Practice has telephonic or other access to translator(s) for all languages common to Practice's established patients.

INDIVIDUAL CARE MANAGEMENT (ICM)**Characteristic ICM-1: Staff Training in Care Management**

Practice Site leaders and staff have been trained/ educated and have comprehensive knowledge of the PCHCH model, the planned care model (Wagner), and Practice transformation concepts.

Characteristic ICM-2: Care Management – Integrated Team

Practice Site has ability to deliver coordinated care management services with an integrated team of multi-disciplinary clinicians and other professionals, and non-clinical support/operational staff and a systematic approach is in place to deliver comprehensive care that addresses patients' full range of health care needs.

Characteristic ICM-3: Care Management – Use of Guidelines

Systematic approach is in place to ensure that evidence-based care guidelines are established and in use at the point of care by all team members of the Practice Site.

Characteristic ICM-4: Ongoing Care Management Protocols –All Patients

Practice addresses all the following planning and follow-up stages of a patient's care, including pre-visit, during visit, and between visit follow-up:

- (a) Conducts pre-visit planning (e.g. reviews chart before visit, notifies patient of tests needed before the visit);
- (b) Develops an individualized care plan including treatment goals in collaboration with patient that addresses patient's comprehensive care needs;
- (c) Reviews care plan and assesses progress toward treatment goals at each visit ;
- (d) Provides patient with clinical summary for each office visit;
- (e) Assesses and supports patients in adopting healthy behaviors;
- (f) Assesses and arranges or provides treatment for behavioral health and substance abuse problems;
- (g) Follows up with patients when they have not kept important appointments; and
- (h) Follows up with patients between visits (check on self-care, medication fills, treatment plan, schedules visits, and refers for tests/follow-up care).

Characteristic ICM-5: Chronic Condition – Care Management

At least one chronic condition has been identified for initial focus, and the Practice has assembled and is monitoring all key clinical data, clinical outcomes measures, process measures, and patient satisfaction/office efficiency measures.

Characteristic ICM-6: Chronic Condition – Action Plans

Action plan development and self-management goal-setting is systematically offered to all patients with the chronic condition selected for initial focus.

Characteristic ICM-7: Chronic Condition – Appointments

A systematic approach is in place for appointment tracking and generation of reminders for all patients with the chronic condition selected for initial focus.

Characteristic ICM-8: Chronic Condition – Follow-Up

A systematic approach is in place to ensure that follow-up for needed services are provided for all patients with the chronic condition selected for initial focus.

Characteristic ICM-9: Chronic Condition – Planned Visits

Planned visits are offered to all patients with the chronic condition selected for initial focus.

Characteristic ICM-10: Chronic Condition – Group Visits

Group visit option is available for all patients with the chronic condition selected for initial focus (as appropriate for the patient).

Characteristic ICM-11: Medication Review

Medication review and management is provided at every visit for all patients, and recommends clinically equivalent generic substitutions where possible giving due consideration to cost and patients' benefits design.

Characteristic ICM-12: Electronic Prescribing Utilized

Practice employs an electronic prescribing system, which increases patient safety, convenience and lowers medication cost with a system that has the following capabilities:

- (a) Integrates with the patients' medical records;
- (b) Connects to pharmacies and pharmacy benefit managers;
- (c) Receives renewal requests electronically;
- (d) Generates patient-specific alerts at the point of care, including drug-drug interactions, drug-disease interactions, and drug-allergy alerts;
- (e) Informs clinician of generic alternatives;
- (f) Provides clinician with patient-specific formulary coverage information.

Characteristic ICM-13: Self-Management

Action plan development and self-management goal-setting is systematically provided to all patients with chronic conditions or other complex health care needs.

Characteristic ICM-14: Appointments

A systematic approach is in place for appointment tracking and generation of reminders for all patients.

Characteristic ICM-15: Follow-Up

A systematic approach is in place to ensure follow-up for needed services for all patients.

Characteristic ICM-16: Planned Visits

Planned visits are offered to all patients with chronic conditions.

Characteristic ICM-17: Group Visits

Group visit option is available to all patients with chronic conditions.

TEST AND IMAGING RESULTS (TIR)**Characteristic TIR-1: Documented Test Tracking Procedures**

Practice has test tracking process/procedure documented, which requires tracking and follow-up for all tests and test results, with identified timeframes for notifying patients of results.

Characteristic TIR-2: Systematic Testing

Systematic approach and identified timeframes are in place for ensuring patients receive needed tests and the Practice obtains results, using a shared decision-making approach which gives dues to consideration to cost, benefits, and patients' benefits design.

Characteristic TIR-3: Staff Training on Test Tracking

All clinicians and appropriate office staff are trained to ensure adherence to the test-tracking procedure; all training is documented either in personnel file or in training logs or records.

Characteristic TIR-4: Patient Contact Information Updated

Process is in place for ensuring patient contact details are kept up to date.

Characteristic TIR-5: Lab and Imaging Tracking and Follow-Up

Practice has the following procedures and systems (preferably automated and electronic) in place to order, track, receive, and follow-up on laboratory tests and imaging exams for all its patients:

- (a) Orders tests and imaging exams online with computerized order entry system;
- (b) Tracks all lab tests and imaging until results are available;
- (c) Flags overdue lab and imaging results;
- (d) Flags abnormal lab and imaging results, as well as duplicate results;
- (e) Follows up with patients for all lab and imaging results-normal or abnormal; and
- (f) Ensures all lab and imaging test results are recorded in the medical record.

PREVENTIVE SERVICES (PS)**Characteristic PS-1: Primary Prevention Program**

Primary prevention structure and processes in place that focuses on identifying and educating patients about personal health lifestyle behaviors to reduce their risk of disease and injury.

Characteristic PS-2: Preventive Services Approach

A systematic approach is in place to provide preventive services.

Characteristic PS-3: Preventive Services Program

Practice has a systematic approach in place to ensure the provision/documentation of preventive services and uses assessment tools and provides advice regarding lifestyle changes and risk factors.

Characteristic PS-4: Prevention Services Protocols

Standing order protocols are in place allowing Practice Site care team members to authorize and deliver preventive services according to physician-approved protocol without examination by a clinician.

Characteristic PS-5: Secondary Prevention Program

Secondary prevention program is in place to identify and treat both symptomatic and asymptomatic persons who have already developed risk factors or pre-clinical disease, but in whom the disease itself has not become fully clinically established.

Characteristic PS-6: Promote Well Care

Strategies are in place to promote ongoing well care visits and screenings for all populations.

Characteristic PS-7: Comprehensive Health Risk Assessment

Practice conducts a baseline comprehensive health risk assessment for all patients to help identify health risks and needs as a foundation for establishing an individualized plan of care.

Characteristic PS-8: Care Coordination Through Collection of Health Encounter Patient Data

Practice has process in place to inquire about a patient's outside health encounters and has capability to incorporate information in patient tracking system or medical record.

Characteristic PS-8: Staff Training in Health Promotion

Staff receives regular training and/or communications in health promotion and disease prevention and incorporates preventive-focused practices into ongoing administrative operations.

COMMUNITY SERVICES & RESOURCES (CSR)**Characteristic CSR-1: Comprehensive Review of Community Resources**

Organization/Practice has conducted a comprehensive review of community resources for the geographic population that they serve, in conjunction with Practice Sites.

Characteristic CSR-2: Community Resource Database

Organization/Practice maintains a community resource database based on input from Practice Sites and patients that serves as a central repository of information for all Practice Sites.

Characteristic CSR-3: Collaboration with Community Resources

Organization/Practice in conjunction with Practice Sites has established collaborative relationships with appropriate community-based agencies and organizations.

Characteristic CSR-4: Staff Training on Shared Decision-Making and Referring Patients to Community Resources

All members of Practice Site care team involved in establishing care treatment plans have received training on shared decision-making and community resources so they can identify and help educate and engage patients in making appropriate referrals.

Characteristic CSR-5: Community Resource Referral System

Systematic approach is in place for referring patients to community resources.

Characteristic CSR-6: Tracking Community Resource Referrals

Systematic approach is in place for tracking referrals of high-risk patients to community resources made by the care team, and making every effort to ensure that patients complete the referral activity.

Characteristic CSR-7: Follow-Up of Community Resource Referrals

Systematic approach is in place for conducting follow-up with high-risk patients regarding any indicated next steps as an outcome of their referral to a community-based program or agency.

SELF-MANAGEMENT SUPPORT (SMS)**Characteristic SMS-1: Staff Training on Self-Management Support**

Practice identifies selection criteria for choosing one or more self-management programs to make available to patients. After making its selection:

- (a) The Practice designates at least one member of the care team to learn how to implement one or more of the chosen self-management programs.
- (b) This person regularly works with other members of the clinical team to assure that the benefits of selected self-management programs are available to appropriate patients.

Characteristic SMS-2: Chronic Condition – Self-Management Support

Self-management support, including shared goal-setting, is offered to all patients with the Chronic Condition selected for initial focus (based on prevalence of condition within the Practice, as well as need, suitability, and patient interest).

Characteristic SMS-3: Chronic Condition – Self-Management Support Follow-Up

Systematic follow-up occurs for all patients with the Chronic Condition selected for initial focus who are engaged in self-management support to discuss action plans and goals, and provide supportive reminders.

Characteristic SMS-4: Assessment of Patient Self-Care Capabilities

Practice assesses and monitors a patient's/family's/caregiver(s)' capability and confidence in effectively performing self-care responsibilities.

Characteristic SMS-5: Patient and Care Team Surveys of Self-Management Support

Regular patient experience/satisfaction and care team member surveys are conducted for patients and team members engaged in self-management support, to identify areas for improvement, with results actively utilized to implement follow-up quality improvement activities.

Characteristic SMS-6: Self-Management Support Implementation

Self-management support, including shared goal setting, is offered to patients with all Chronic Conditions (based on need, suitability and patient interest).

Characteristic SMS-7: Self-Management Support Follow-Up

Systematic follow-up occurs for patients with all chronic conditions who are engaged in self-management support to discuss action plans and goals, and provide supportive reminders.

Characteristic SMS-8: Self-Management Support for All Patients

Support and guidance in establishing and working towards a self-management goal is offered to every patient, including well patients.

PATIENT WEB PORTAL (PWP)**Characteristic PWP-1: Evaluation of Patient Web Portal Systems**

Available vendor options for purchasing and implementing a patient Web portal system have been evaluated.

Characteristic PWP-2: Patient Web Portal Risk Assessment

Organization/Practice has assessed liability and safety issues involved in maintaining a patient Web portal at any level and developed policies and procedures that allow for a safe and efficient exchange of information.

Characteristic PWP-3: Scheduling Using Patient Web Portal

Ability for patients to request and schedule appointments electronically is activated and available to all patients.

Characteristic PWP-4: Patient Web Portal Logs of Patient Information

Ability for patients to log and/or graphs results of self-administered tests (e.g., daily blood glucose levels) is activated and available to all patients.

Characteristic PWP-5: Clinician Alerts to Potential Health Issues

Clinicians are automatically alerted by system regarding self-reported patient data that indicates a potential health issue.

Characteristic PWP-6: Implementation of Electronic Visits

Ability for patients to participate in electronic visits (e-visits) is activated and available to all patients.

Characteristic PWP-7: Patient Use of Interactive Web Portal

Clinicians are using patient portal to send automated care reminders, health education materials, links to community resources, educational Websites and self-management materials to patients electronically.

Characteristic PWP-8: Patient Web Portal – Personal Health Record (PHR)

Patient portal system includes capability for patient to create personal health record, and is activated and available to all patients.

Characteristic PWP-9: Patient Review of Test Results

Ability for patients to review test results electronically is activated and available to all patients.

Characteristic PWP-10: Prescription Renewals

Ability for patients to request prescription renewals electronically is activated and available to all patients.

Characteristic PWP-11: Patient Self-Management Support

Ability for patients to graph and evaluate results of self-administered tests for self-management support purposes is activated and available to all patients.

Characteristic PWP-12: Patient Review of PHI

Ability for patients to have access to view registries and electronic medical records online that contain patient personal health information (PHI) that has been reviewed and released by the clinician and/or the Practice is activated and available to all patients.

Characteristic PWP-13: Availability of Patient Decision Support Tools

Patients are provided with education decision support tools which assist in the shared decision making process regarding their care options.

COORDINATION OF CARE (COC)**Characteristic COC-1: Chronic Condition – Coordination of Care**

For every patient with chronic condition selected (based on high prevalence/high risk) for initial focus, mechanism is established for being notified of each patient admission and discharge, or other type of encounter, at facilities with which the PCHCH clinician has admitting privileges or other ongoing relationships.

Characteristic COC-2: Medical Record Information Exchange

Process is in place for exchanging necessary medical records and discussing continued care arrangements with other clinicians, including facilities, for all patients with high prevalence/high risk chronic condition selected for initial focus.

Characteristic COC-3: Tracking Coordination of Care

Approach is in place to systematically track care coordination activities for each patient with high prevalence/high risk chronic condition selected for initial focus.

Characteristic COC-4: Chronic Condition- Health Issue Alerts

Process is in place to systematically flag for immediate attention any patient issue that indicates a potentially time-sensitive health issue for all patients with high prevalence/high risk chronic condition selected for initial focus.

Characteristic COC-5: Written Transition Plans

Process is in place to ensure that written transition plans are developed, in collaboration with patient and caregivers, where appropriate, for all patients who are transitioning to and from the hospital.

Characteristic COC-6: Coordination of Care with Payer Case Manager

Process is in place to coordinate care with employer and /or payer case manager for patients with complex or catastrophic conditions.

Characteristic COC-7: Coordinating Care Site Transitions

Practice has the following processes in place with local health care facilities to help ensure smooth transitions in care for its patients who require transfers in the site of care. The processes include the ability to:

- (a) Identify patients with an unplanned hospital admission or emergency department visit;
- (b) Transmit a patient's clinical information to hospital or emergency department in timely fashion;
- (c) Make contact with patients having unplanned hospital admission or emergency department visit within reasonable timeframe after being notified (defined in PCHCH's policies);
- (d) Establish formal care agreements with hospitalists who provide care to PCHCH patients;
- (e) Develop a written care plan in collaboration with patient and family when pediatric patients transition from pediatric care to adult care; and
- (f) Ensures hospitalizations and emergency department visits are documented in the patient's medical record.

Characteristic COC-8: Program Documentation and Training

Practice has written procedures and/or guidelines on care coordination processes, and appropriate members of care team are trained on care coordination processes and have clearly defined roles within that process.

Characteristic COC-9: Coordination of Care Program for All Chronic Conditions

Care coordination capabilities are extended to all patients with chronic conditions that need care coordination assistance.

Characteristic COC-10: Coordination of Care Program for All

Care coordination capabilities are extended to all patients that need care coordination assistance.

SPECIALIST REFERRAL PROCESS (SRP)**Characteristic SRP-1: Specialist Referrals for High Volume Specialists**

Procedures are in place to guide each phase of the specialist referral process – including desired timeframes for appointment and information exchange - for preferred or high volume specialists.

Characteristic SRP-2: Specialist Referrals for Other Key Specialists

Procedures are in place to guide each phase of the specialist referral process – including desired timeframes for appointment and information exchange – when patients are referred to other key specialists.

Characteristic SRP-3: Specialist Referral Directory

Directory is maintained listing specialists to whom patients are routinely referred--specialists are well known to the Practice in terms of clinical expertise, timeliness of access, and timely communication of patient reports to the PCHCH.

Characteristic SRP-4: Patient Information on Specialist Referrals

Organization/Practice or Practice Site has developed specialist referral materials supportive of process and individual patient needs.

Characteristic SRP-5: Staff Makes Specialist Appointments

Practice Site or designee routinely offers assistance to patients to make specialist appointments on behalf of patients.

Characteristic SRP-6: Electronic-Based Tools for PCP and Specialist

Each facet of the interaction between preferred/high volume specialists and the PCPs at the Practice Site level is automated by using electronically-based tools and processes to avoid duplication of testing and prescribing across multiple care settings.

Characteristic SRP-7: Track and Follow-Up on Specialist Referral

Practice employs the following mechanisms to track and follow-up on referrals to clinicians outside the Practice:

- (a) Provides the patient and referral clinician with the reason for the consultation and pertinent clinical findings;
- (b) Tracks referrals electronically (preferably), and determines if and when the patient was seen by the specialist;
- (c) Documents the referral dates in medical record;
- (d) Follows-up to obtains a report back from the referral clinician; and
- (e) Contacts patient for follow-up if necessary based on consult report from specialist.

Characteristic SRP-8: Staff Training on Specialist Referral Process

Appropriate Practice Site staff is trained on all aspects of the specialist referral process.

Characteristic SRP-9: Patient and Care Team Member Surveys on Specialist Care

Practice Site regularly evaluates patient and care team member satisfaction with most commonly used specialists, to ensure physicians are referring patients to specialists that meet their standards for patient-centered care, and that patients are pleased with quality of engagement and support offered by specialists.

PERFORMANCE REPORTING (PRT)**Characteristic PRT-1: Performance Reporting - High Prevalence/High Risk Condition Patient Population**

Performance reports are generated that allow tracking and comparison of results at a specific point in time across the population of patients identified as having high prevalence and/or high risk conditions.

Characteristic PRT-2: Performance Reporting of Practice Levels

Performance reports are generated at the Organization/Practice, individual clinician and clinic or Practice Site level.

Characteristic PRT-3: Performance Reporting Validation

Data contained in performance reports has been fully validated and reconciled to ensure accuracy.

Characteristic PRT-4: Performance Reporting – Trends Analysis and Action

Practice receives and acts on trend data showing its impacts on unnecessary or avoidable utilization (e.g., Emergency Department and re-hospitalizations) and reducing costs as well as cost growth for its patient population as a whole over time.

Characteristic PRT-5: Performance Reporting for All Ages

Performance reports are generated for all patients, if applicable.

Characteristic PRT-6: Performance Reporting – Prevention

Performance reports include all patients defined in Characteristic PR-Registry Use for Prevention.

Characteristic PRT-7: Performance Reporting – Population Based

Performance reports include all patient information defined in Characteristic PR-Registry Clinical Information.

Characteristic PRT-8: Performance Reporting – Specialist Services

Performance reports include information on services provided by specialists.

Characteristic PRT-9: Performance Reporting – Other Services

Performance reports include information on services provided by diagnostic testing, hospitals, and other health care clinicians or providers.

Characteristic PRT-10: Continuous Quality/Customer Satisfaction Improvement Activities - Trend Analysis and Action.

Practice actively pursues excellence in care quality and customer service by analyzing performance trends based on quality of care process and outcomes measures, as well as obtaining feedback from patients/families/caregivers (through surveys and other means), and proactively employs this information to continuously improve its performance and ability to provide a high level of service to its patient population

Characteristic PRT-11: Performance Reporting Transparency

Practice has written policies and documented procedures for openly sharing its performance data and trends with patients, payers, and governmental agencies for public reporting and comparative purposes, and willingly discusses this performance information with current and prospective patients/families/caregivers.

PCHCH ORGANIZATIONAL CORE (CORE)**Characteristic COR-1: Organizational Structure**

Practice has a clearly defined organizational structure outlining direct and indirect oversight responsibility throughout the organization and designated facilitator in three areas:

- (a) Teamwork;
- (b) Clinical order tracking/transition of care; **and**
- (c) Continuous quality improvement.

Characteristic COR-2: Organization Documents

PCHCH's documents address:

- (a) Philosophy or mission statement;
- (b) Organizational framework for PCHCH operation;
- (c) The population served; **and**
- (d) Organizational oversight and reporting requirements of the program.

Characteristic COR-3: Regulatory Compliance

PCHCH implements and maintains a regulatory compliance program that tracks and ensures compliance with applicable laws and regulations.

Characteristic COR-4: Information Management

PCHCH's information system(s) supports effective and efficient internal operation and timely delivery of health care services and care coordination inside and outside the Practice.

Characteristic COR-5: Information Confidentiality and Security

PCHCH has policies and procedures in place to provide for the confidentiality and security of its information systems.

Characteristic COR-6: Confidentiality of Individually Identifiable Health Information

PCHCH has policies and procedures in place to protect the confidentiality of individually identifiable health information' complies with all governing regulatory requirements, and specifies which employees can access and release such information, and under which circumstances.

Characteristic COR-7: Staff Qualifications - Job Descriptions

PCHCH has written job descriptions for staff that address requirements pertinent to the scope of the positions' roles and responsibilities, including required education, training, professional competencies (including licensure/certification requirements), and professional experience.

Characteristic COR-8: Staff Training Requirements

PCHCH has ongoing training program which is documented and includes initial orientation, PCHCH culture, approach to patient engagement and shared decision-making, team member roles and responsibilities, provision of courteous customer service in a culturally sensitive manner, procedures and responsibilities for care coordination, referrals, and follow-up, proper handling of individually identifiable health information, and maintenance of professional competency.

Characteristic COR-9: Staff Teamwork Optimization and Job Satisfaction

PCHCH ensures team operates in an optimal manner by fully employing individual team member skills and professional license competencies, and ensuring a positive and rewarding work environment and job experience.

Characteristic COR-10: Patient Empowerment and Engagement

PCHCH ensures patients/families/caregivers are educated and actively engaged in their rights, roles and responsibilities in the shared decision-making process, and are provided with consumer friendly , culturally/linguistically sensitive, educational information on their condition(s) and health care needs, as well as educational decision aids.

Characteristic COR-11: Patient Satisfaction

PCHCH surveys patients/families/caregivers on all aspects of its operation, and actively utilizes results to ensure an optimal patient experience.

Characteristic COR-12: Patient Safety Mechanism

PCHCH has a mechanism in place to respond on an urgent basis to situations that pose an immediate threat to the health and safety of its patients.

Characteristic COR-13: Optimizing Care Value - Awareness of Clinical Advances

PCHCH maintains awareness of latest clinical advances in diagnosis and treatment, and disseminates this information on regular basis to members of care team.

Characteristic COR-14: Optimizing Care Value - Protocols for Consideration of Cost Effective Diagnostic/ Treatment Options

PCHCH establishes policies and protocols that, when competing therapeutically comparable diagnostic procedures and treatment options are available for a given patient/condition, cost options will be discussed and offered to the patient.

Characteristic COR-15: Provision of Cost/Benefit Information to Patients

PCHCH will provide patient-friendly cost/benefit educational information to patients/families/caregivers, as well as any available decision aids, to assist in shared decision-making on selecting diagnostic procedures, treatments, and potential outcomes in terms of cost, and impact on function and quality of life.

Characteristic COR-16: Establishing and Utilizing a Trusted Referral Network

PCHCH establishes a network of trusted diagnostic and specialty care clinicians that are committed to the PCHCH approach to care delivery and coordination, have demonstrated clinical expertise and maintain high care standards, are patient-centric, and provide timely interactive communications on patient status and clinical data with the PCHCH.