PATIENT-CENTERED MEDICAL HOMES – STANDARD 5

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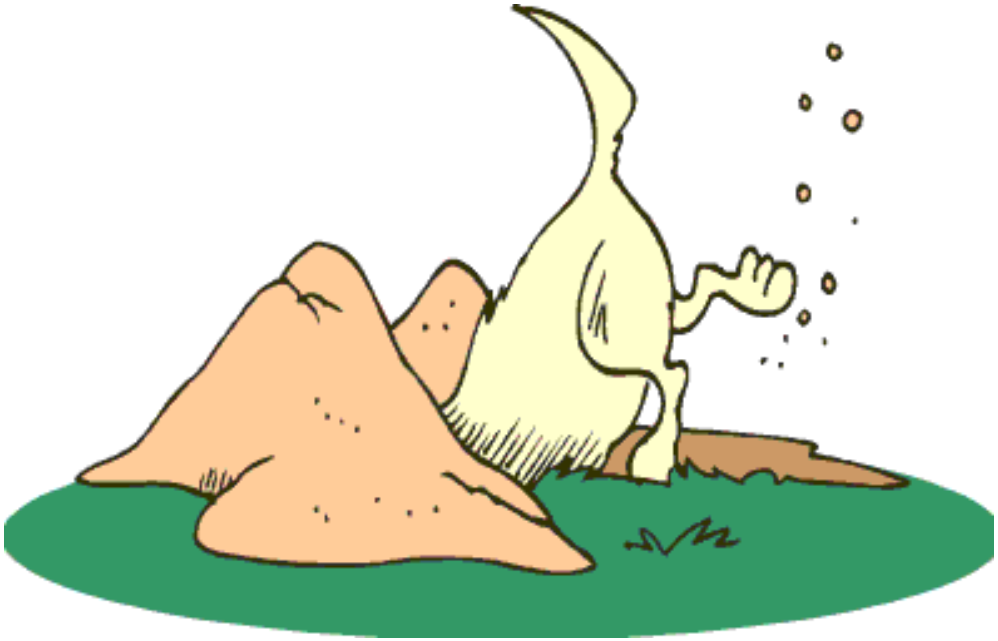
DIGGING INTO PCMH STANDARDS 5A, 5B, 5C



PCMH 5A

CRITICAL FACTORS = FACTORS 1 AND 2

Test Tracking and Follow-Up 6 *points*

Factors 1-10 align with 2011 PCMH 5A Factors 1-10

The practice has a documented process for and demonstrates that it:

1. Tracks lab tests until results are available, flagging and following up on overdue results
2. Tracks imaging tests until results are available, flagging and following up on overdue results
3. Flags abnormal lab results, bringing them to the attention of the clinician
4. Flags abnormal imaging results, bringing them to the attention of the clinician
5. Notifies patients/families of normal and abnormal lab and imaging test results

PCMH 5A

CRITICAL FACTORS = FACTORS 1 AND 2

Test Tracking and Follow-Up **6 *points***

The practice has a documented process for and demonstrates that it:

6. Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for adults)
7. More than 30 percent of laboratory orders are electronically recorded in the patient record+ ***(New)***
8. More than 30 percent of radiology orders are electronically recorded in the patient record+ ***(New)***
9. Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record+ *(Increase in Percentage)*
10. More than 10 percent of scans and tests that result in an image are accessible electronically++ ***(New)***

+ Stage 2 Core Meaningful Use Requirement

++ Stage 2 Menu Meaningful Use Requirement

PCMH 5A: DOCUMENTATION

- Factors 1-6: Documented process and evidence showing how the process is met for each factor.
- Factor 7,8,9,and 10: Report at least 3 months duration reported as a percentage result

5A 3,5

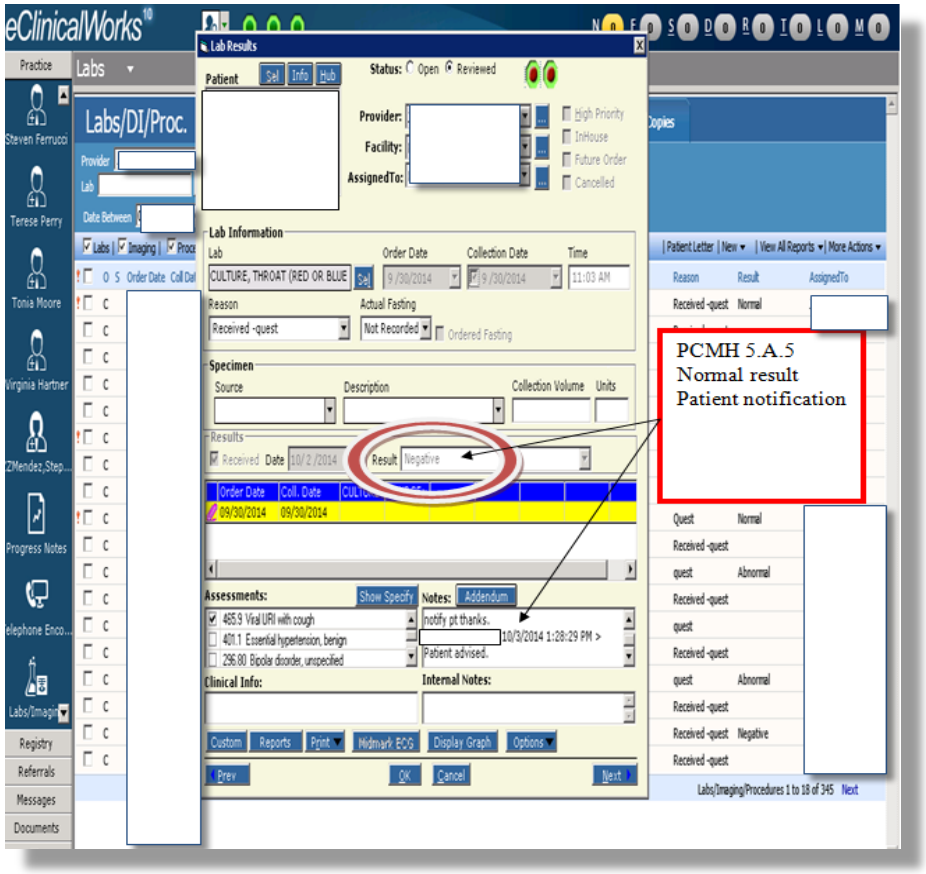
b. The patient is notified of lab results via telephone, mail or by an already scheduled follow-up visit as appropriate.

i. Critical Lab Results - Patients are notified by phone of any critical labs by the provider or the nurse. Patient instructions and follow up are documented in the EHR.

ii. Normal Lab Results – Patients are notified by mail and copy of letter is found in the EHR.

iii. Abnormal labs results that are expected or are normal for patient– Patients are notified by mail and copy of letter is found in the EHR. Patients may also be notified of their results at their previously scheduled follow up appointment.

iv. Abnormal labs results that were not expected or normal for patient – Depending upon the urgency of the lab result, patients are notified by a phone call or letter. Documentation of the instructions and follow up are found in the EHR.



PCMH 5B

MUST-PASS

CRITICAL FACTOR = FACTOR 8

Referral Tracking and Follow-Up ***6 points***

The practice:

1. Considers available performance information on consultants/specialists when making referral recommendations (***New)***
2. Maintains formal and informal agreements with a subset of specialists based on established criteria ***(New)***
3. Maintains agreements with behavioral healthcare providers ***(New)***
4. Integrates behavioral healthcare providers within the practice site ***(New)***
5. Gives the consultant or specialist the clinical question, the required timing and the type of referral *(Aligns with 2011 PCMH 5B_1)*

PCMH 5B

MUST-PASS

CRITICAL FACTOR = FACTOR 8

Element 5B: Referral Tracking and Follow-Up *6 points*

The practice:

6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan *(Aligns with 2011 PCMH 5B_1)*
7. Has the capacity for electronic exchange of key clinical information+ and provides an electronic summary of care record to another provider for more than 50 percent of referrals+ *(Aligns with 2011 PCMH 5B_6 and 7)*
8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports *(Aligns with 2011 PCMH 5B_2 and 3)*
9. Documents co-management arrangements in the patient's medical record *(Aligns with PCMH 5B_4)*
10. Asks patients/families about self-referrals and requesting reports from clinicians *(Aligns with PCMH 5B_5)*

+ Stage 2 Core Meaningful Use Requirement

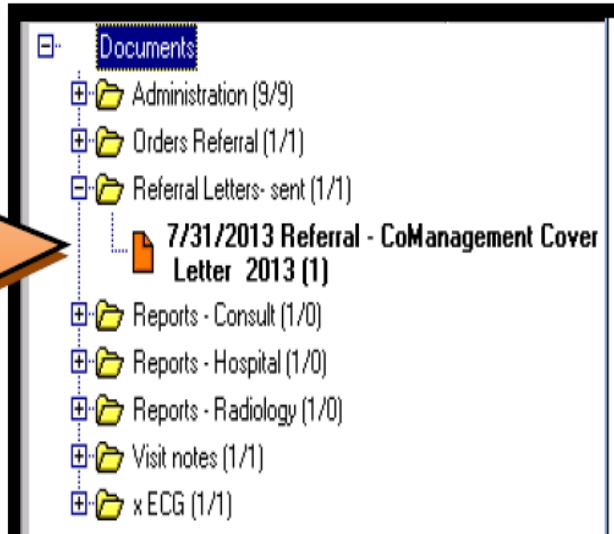
PCMH 5B: DOCUMENTATION

- Factor 1: Example
- Factor 2 and 3: One example for each factor
- Factor 4: Materials
- Factors 5,6,8, and 10: Documented process and a report, log, or other means evidencing referral tracking and follow-up. If presenting a report it must be at least over a week's period.
- Factor 7: Screenshot showing capability and a report at least 3 month duration
- Factor 9: Three examples

PCMH 5B Factor 5, Factor 6, and Factor 8 (report)

Patient's Last Name	Patient's First Name	Patient#	Referred To	Referred By	Referral Date	Referral Reason *(PCMH 5B-5)*	Referral Urgency *(PCMH 5B-5)*	Clinical Info Provided (Y/N/NA) *(PCMH 5B-6)*	Appoint Date	Date Notes/Result Expected *(PCMH 5B-8)*	Referral Follow-Up Dates *(PCMH 5B-8)*	Follow-Up Comments	Date Result or Report Obtained	Referral Comp? (Y/N) *(PCMH 5B-8)*
Example below														
Brown	John	11011279	Dr. Sawbones	Dr. Nice	9/20/2012	Knee Pain	Non-Urgent	Y	9/30/2012	10/7/2012	10/5/2012	Report to be faxed to office on 10/8/12	10/8/2012	Y

Example 1: Cardiology Referral



PCMH 5B Factor 9 Documented Co-Management Agreement

July 31, 2013

Note to Specialist (Co-Management Agreement)

Regarding Patient: [redacted]

Dear Provider,

[redacted] Health Center would like to thank you for agreeing to see our patient. We are very grateful for the skills and expertise of our consultants in helping us guide the care of our patients.

Unless otherwise stated in the referral, we will continue providing primary care for this patient while you address the referring issue.

In order to provide timely and un-fragmented care, we ask that you please send all documentation and recommendations to our clinic within two weeks of any patient encounter.

Feel free to fax the information to 4[redacted]

As a medical home team, we appreciate your partnership in caring for our patients.
If you have any questions or concerns, please feel free to contact our Referral Coordinator, [redacted]

Regards,

[redacted] MD, FAAFP

PCMH 5C

Coordinate Care Transitions *6 points*

The practice:

Factors 1-5 and 7 align with 2011 PCMH 5C Factors 1-5, 7, and 8

1. Proactively identifies patients with unplanned hospital admissions and emergency department visits
2. Shares clinical information with admitting hospitals and emergency departments
3. Consistently obtains patient discharge summaries from the hospital and other facilities
4. Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit
5. Exchanges patient information with the hospital during a patient's hospitalization
6. Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners ***(New)***
7. Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care+ *(Aligns with 2011 PCMH 5C_7 and 8)*

+Stage 2 Core Meaningful Use Requirement

PCMH 5C DOCUMENTATION

- Factor 1: Documented process and a log or report listing patients.
- Factor 2: Documented process and 3 examples
- Factor 3: Documented process and 3 examples
- Factor 4: Documented process and 3 examples
- Factor 5: Documented process and 3 examples
- Factor 6: Documented process
- Factor 7: Report of a 3 month duration reported as a percentage

IMPLEMENTATION: PCMH 5C Factors 1 and 5 Documented Process

Admission to the Emergency Room or Hospital

1. Providers communicate appropriate clinical information with the emergency room or hospital when patients are sent and/or admitted for care. Clinical information is provided via fax or a telephone conversation between the CCC provider and admitting physician at the facility.

Exchange of Information

1. CCC utilizes hospitalists at area hospitals to admit and follow patients who require hospitalization. Information is exchanged at the time of admission, during the hospitalization, and at the time of discharge to ensure continuity of care when transitioning care back to the health center or another setting is well coordinated.

Factor 4

Discharge from the Emergency Room or Hospital

1. Hospital providers automatically forward patient discharge summaries at the time of discharge from the Emergency Room or from an inpatient stay via fax to CCC.
2. Within one business day of receipt of a discharge summary from an inpatient hospital stay or an emergency room visit, front desk staff confers with the patient's primary care provider to determine if a follow-up visit is indicated.
3. When a follow-up visit is recommended by the primary care provider the front desk staff call the patient within 1 business day or sooner if advised by the primary care provider and schedule an appointment for follow-up care as indicated by the primary care provider.
4. Follow up visits are scheduled for most patients except in instances when a patient went to the emergency room for a broken bone or another acute complaint that was resolved during that visit to the hospital.
5. Front desk staff also schedule follow up visits upon the patient's request, following an inpatient stay or an emergency department visit.
6. Front desk staff utilizes a spreadsheet (log) to track the patients that require a follow up visit to CCC. The spreadsheet tracks the patient's name, date of admission/ED visit, whether or not there was any exchange of information between CCC and the outside facility, whether the discharge summary was received, and if so, the date it was received, and the date of the patient's follow up visit with his/her primary care provider.

PCMH 5C Factors 1 and Factor 4 - Report

Admit Date	Discharge Date	Patient Name	Patient DOB	Physician	Date Contacted (F/U)
3/31/2015	4/17/2015				4/20/2015
4/5/2015	4/14/2015				4/17/2015
4/10/2015	4/14/2015				4/17/2015
4/10/2015	4/16/2015				4/19/2015
4/11/2015	4/14/2015				4/17/2015
4/11/2015	4/16/2015				4/19/2015
4/11/2015	4/20/2015				4/23/2015
4/14/2015	4/14/2015				4/17/2015
4/14/2015	4/14/2015				4/17/2015
4/14/2015	4/17/2015				4/20/2015
4/14/2015	4/17/2015				4/20/2015
4/15/2015	4/15/2015				4/18/2015
4/15/2015	4/16/2015				4/19/2015
4/15/2015	4/17/2015				4/20/2015
4/15/2015	4/19/2015				4/22/2015
4/16/2015	4/16/2015				4/19/2015
4/16/2015	4/17/2015				4/20/2015
4/16/2015	4/17/2015				4/20/2015
4/16/2015	4/19/2015				4/22/2015
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4/17/2015	4/19/2015				4/22/2015
4/17/2015	4/20/2015				4/23/2015
4/18/2015	4/19/2015				4/22/2015
4/18/2015	4/19/2015				4/22/2015
4/18/2015	4/20/2015				4/23/2015
4/18/2015	4/20/2015				4/23/2015
4/19/2015	4/20/2015				4/23/2015
4/19/2015	4/20/2015				4/23/2015
4/19/2015	4/20/2015				4/23/2015
4/19/2015	4/20/2015				4/23/2015

PCMH 5C Factor 4

QUESTIONS?

Q&R ASSIST

PCMH Assist
Patient Centered Medical Home

Care Spectrum Plus
COORDINATED CARE FOR ALL

Quality First Healthcare Consulting
Where Results Begin