A Simplified highly Effective PCMH Model

Arkansas Department of Health
Office of Rural Health and Primary Care
Rural Health Clinic Quality Meeting

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VP Clinical Services
April 13, 2018
The Compliance Team, Inc.
Exemplary Provider Accreditation Program

“Every patient deserves exemplary care.”

We accredit:
DMEPOS
Pharmacy Services:
  - Community Pharmacy
  - Sterile Compounding
  - Non-sterile Compounding
  - Long-Term Care
  - Specialty Drugs
  - Infusion
  - Travel/Retail Clinic
  - Patient Centered Pharmacy Home
Ocularist
Rural Health Clinics
Patient Centered Medical Home
Goals for the Day

• Understand the value of PCMH to the practice

• Understand the PCMH Standards

• Learn how to begin the PCMH process in your practice

• Have a working knowledge of a PCMH Survey
Elements of the PCMH Model

Comprehensive Care
Patient Centered
Coordinated Care
Accessible Services
Quality and Safety
What is a Patient Centered Medical Home?

Clearly it’s a journey, not a destination!
Why Become a Patient Centered Medical Home?

• Puts patients first
• Make primary care more accessible
• Improves patient outcomes
• Improves staff satisfaction
• Improves patient satisfaction
• Mitigates health disparities
Why Become a Patient Centered Medical Home?

“Quality care starts in the office, is nurtured in the exam room, cultivated online, and harvested in quality measures and patient follow-up interviews.”
Why Become a Patient Centered Medical Home?

• Every $1.00 increase in Primary care spending equals $13.00 in savings
• This study provides another piece of evidence supporting the hypothesis that PCMH can lead to lower cost of care.
• Nevertheless, this study shows a consistent pattern, suggesting a robust cost saving across all the cost categories. Study shows the PCMH impact on each of the three main components of the total cost: acute inpatient, outpatient, and professional costs.

(Geisinger Study)
Barriers to becoming a Patient-Centered Medical Home?

- Resistance to change
  - Inadequate financial resources
  - Low workforce
  - Low adaptive reserve
  - Your EHR
  - Staff buy in
  - Motivation
Most PCMH Programs Can Be...

- Rigid
- Burdensome
- Labor Intensive
- Expensive
- Overwhelming

Too much data tracking robs time devoted to patient care.
Rethinking PCMH?

• Anything taking you away from patient care is heading in the wrong direction!

• The Compliance Team’s PCMH Accreditation Program focuses on getting back to patient care and looks at day to day operations.

• It’s a Winning Approach for both Clinics and Patients.
Good News

RHCs are already doing much of this informally but not getting credit for it!!!

Becoming a PCMH formalizes the process and identifies performance gaps.
Introduction to the TCT Quality Standards

Patient Centered Medical Home
TCT’s Approach to Quality Standards

“Operational excellence Leads to clinical excellence.”

Sandy Canally, RN
TCT’s Approach to Quality Standards

PATIENT PROTECTION ZONE™
PROCEED WITH CAUTION. The healthcare delivery procedure identified in the following Quality Standard is prone to Preventable Medical Errors that directly cause harm to patients and others.
PCMH 1.0 The organization provides advanced access to its patients

1) Expanded hours:
   a) Same day appointments for urgent illness.
   b) Some evidence of expanded weekday, evening, and weekend appointment offerings.
   c) Call coverage or arrangement for after-hours emergencies 24/7.
2) The organization provides patients and their family/caregivers written information regarding the Patient-Centered Medical Home and its services.

This information is available in the language(s) of the community served (e.g. brochures, posters, website).
We Start with You!
You choose the Care Team that’s right for you.

Access to Care:
Your primary care provider will develop a plan to maximize your health, provide same-day appointments, after-hours coverage, urgent care needs, and imaging and lab services.

Quality and Safety:
We will provide evidence-based practices, medication management, patient satisfaction feedback, quality improvements, risk management, and regulatory compliance.

Health Information and Technology:
We have electronic medical records, electronic orders and reporting, electronic prescribing, electronic appointment reminders, and electronic referral services available to better coordinate your care.

Care Coordination:
Our Care Navigator provides a link between you and the rest of your health care team, in and out of Kirby Medical Group. Our multi-disciplinary team consists of specialists, nutritionists, a wellness coach, and the Care Navigator.

Care Management:
The Care Teams at Kirby Medical Group promotes Wellness, population management, chronic disease management, patient education, and patient outreach for preventative screenings.

Financial Responsibility:
The patient pays at the right place, at the right time. We have trained coding and billing staff, cost-effective care management, and quality cost benefit decision making.

The Patient Centered Medical Home:
Coordinated, comprehensive, and locally responsible healthcare delivered to the patients of Kirby Medical Group by our Care Teams.

KIRBY MEDICAL GROUP
Learn more about our services at KirbyHealth.org

Stonebridge Internal Medicine

Information For You!
Please request Prescription Refill’s through your Pharmacy 24-48 hours in advance.
Thank You.

2016-2017 FLU SHOTS ARE AVAILABLE

The Compliance Team
Exemplary Provider Accreditation
PCMH 1.0 The organization provides advanced access to its patients.

3) The organization communicates essential practice information to its patients. This information includes:

   a) What patients should bring to each appointment.
   b) How patient calls and prescription requests are handled.
   c) The routes in which patients can attain healthcare access after-hours.
   d) Policies regarding the rescheduling or cancellation of appointments.
The organization provides advanced access to its patients.

4) Evidence exists of advanced access through multiple forms of communication with its patients.

*Examples include:* printed handouts, emailed handouts, email access, patient portals, website postings, texted information, automated phone messages, and phone calls from the office staff.
PCMH 1.0 The organization provides advanced access to its patients

5) The organization follows a **written plan** for handling patient communication that includes acceptable time frames, as determined by organizational policy, for returning patient calls or requests. All calls or requests from patients are documented with a date and time.

*Example*: “All Rx refill calls returned within 1 business day"
Example: Written Plan of Communication

Communication with the Clinic is available via telephone, walk-in, mail, email, texting, and the patient portal.

Policy example:

*If a patient communicates with the Clinic via any of the available modes listed, the Clinic will respond as follows: Monday-Thursday within 24 hours Friday-Sunday within one business day.*
PCMH 1.0 The organization provides advanced access to its patients

*For example*: communication with

- Discharge planners,
- Case workers from physical or behavioral healthcare rehabilitation centers,
- Other healthcare professionals providing services not available in the organization,
- Community outreach programs, and
- Community clubs.
Examples: Resources in the Community
PCMH 2.0 The organization meets the healthcare needs of patients when they are closed.

1) The organization has a written agreement with each entity responsible for handling patient healthcare needs after-hours. The agreement identifies the contracted provider’s scope of services, responsibilities for patient care, and hours of operation.
PCMH 2.0 The organization meets the healthcare needs of patients when they are closed.

2) The organization’s providers receive and review patient healthcare information from after-hours providers. All follow-up is documented in the patient healthcare record.
PCMH 3.0 The organization utilizes a team-based approach for patient-centered coordinated care

1) The organization follows a written plan for the implementation of the Patient Centered Medical Home (PCMH) which includes a description of the work-flow for all team members. The lines of authority and team member responsibilities are clearly defined and reflected in an organizational chart.
PCMH 3.0 The organization utilizes a team-based approach for patient-centered coordinated care

2) The organization assigns new patients to a primary provider who is responsible for that patient’s quality of care.
   • The patient is linked to a provider led care team.
   • For continuity of care, subsequent visits are provided by the same provider led care team.
   • The primary provider or the patient can order a change.
PCMH 3.0 The organization utilizes a team-based approach for patient-centered coordinated care.

Each care team has sufficient support staff. In small practices, it is acceptable to have only one provider-led care team.

For example: Adult, Pediatric, Chronic Care Management, Behavioral Health, and Geriatric Care.
PCMH 3.0 The organization utilizes a team-based approach for patient-centered coordinated care

4) The organization has one or more designated staff members providing Care Coordination interdependently between PCMH Providers, other Healthcare Professionals, and patient care services provided externally.

“CARE COORDINATOR” “NURSE NAVIGATOR” “CARE COACH”
The organization utilizes a team-based approach for patient-centered coordinated care.

5) The Care Coordinator follows a written protocol which includes:
   a) Organizing clinical data to support the ongoing care of patients, monitoring diagnostic tests, and providing written and/or verbal follow-up on results to patients/caregivers, when clinically indicated.
   b) Working with patients/caregivers to develop written care goals.
Example: Written Plan for Care Coordination

Care Coordination of patients will include the following:

1. Organizing clinical data to support the on-going care of patients, tracking diagnostic tests, and providing written and/or verbal follow-up on results to patients/caregivers, when clinically indicated.
   a. use of Excel spreadsheets/EMR module to track data points
   b. communicating with patients/caregivers
   c. providing time-sensitive information to providers
   d. crafting/updating individual care plans based on the data received
2. Working with patients/caregivers to develop written care goals.
   a. discussing goals with patient/caregivers during appointments
   b. updating goals after telephone or email follow-up
3. Utilizing a system to identify and improve the care of high-risk or special-needs patients.
   a. daily huddles
   b. communication boards
   c. meetings with providers
PCMH 3.0 The organization utilizes a team-based approach for patient-centered coordinated care

c) Utilizing a system to identify and improve the care of high-risk or special-needs patients. (e.g. huddles, communication boards, messaging, team meetings)

d) Utilizing **written protocols** with hospitals outlining the referral process and admission and discharge notifications.
Example: Identifying High-Risk or Special Needs Patients

Care Team Huddles
PCMH 3.0 The organization utilizes a team-based approach for patient-centered coordinated care

e) Providing a summary for patients transferring to another medical provider.

f) Providing support to patients/caregivers by helping them connect to community resources.

g) Transition Care Management services (as applicable).
PCMH 3.0 The organization utilizes a team-based approach for patient-centered coordinated care.

6) The Care Coordinator monitors care provided to patients by other providers including:

a) Specialists managing patients’ medications and ordering labs, diagnostics, treatments, procedures, and/or therapies.

b) Pharmacists regarding patients’ medication history, adherence, and any involvement with medication therapy management.
Team-Based Care Coordination
PCMH 4.0 The organization meets all CMS program requirements to demonstrate Meaningful Use of certified EHR technology (as applicable).

1) If the organization attests it meets current CMS program requirements for Meaningful Use through its use of certified electronic health record technology, it can provide evidence to validate these requirements upon request.
PCMH 5.0 The organization ensures patient health records are complete.

1) The organization’s patient health records have evidence of:

**EVIDENCE WILL BE ATTAINED THROUGH AN AUDIT OF THE PATIENT’S HEALTH RECORD**
PCMH 5.0 The organization ensures patient health records are complete.

a) Patient identification and social data that includes:
   i) Identification of the individual(s) included in the care and/or healthcare decisions of the patient
   ii) The preferred language to be used for healthcare discussions with patient’s family members and caregivers
b) Written consent to treat for initiation of care (and informed consent for procedures as required by the State). Properly executed consents include:

i) Unique patient identifiers & the date consent given.

ii) Identification of the signee’s relationship to any patient under the age of majority or unable to give written consent for themselves.

iii) Documentation of legal guardianship as required for minor patients not in their parent’s custody, for patients deemed legally incompetent or receiving behavioral services.
PCMH 5.0 The organization ensures patient health records are complete.

c) Patient status regarding Advanced Directive
d) Pertinent medical history.
e) Evaluation of current health status, which includes:
   i) Vital signs;
   ii) Gender, height, weight and assessment of body mass index or growth percentile;
   iii) Chief complaint;
PCMH 5.0 The organization ensures patient health records are complete.

e) Evaluation of current health status, which includes:

   iv) Behavioral health screening when symptoms are identified (e.g. Patient Health Questionnaire (PHQ 2 or 9) for depression);
PCMH 5.0 The organization ensures patient health records are complete.

e) Evaluation of current health status, which includes:

  v) Cognitive health screening when symptoms are identified or patient is over 65 years of age (e.g. Brief interview of Mental Status (BIMS))

  vi) Updated needs assessment (as appropriate)

  vii) Updated patient-centered health improvement plan™(PCHIP™)

  viii) Updated patient health goals.
PCMH 5.0 The organization ensures patient health records are complete.

f) Summary of the encounter and patient instructions.

g) Lab/diagnostic reports, consultation notes, and any information pertinent to monitor the patient’s progress.

h) Provider orders and documentation of tests, treatments or medications administered in the practice setting.
PCMH 5.0 The organization ensures patient health records are complete.

i) Documentation and reconciliation of current patient medications (including supplements) and patient allergies.

j) Date and signature of the provider related to the encounter.

k) Identification of provider/care team assigned to the patient.
PCMH 5.0 The organization ensures patient health records are complete.

l) Identification of patient’s pharmacy by name, location and contact information.

m) The organization provides an after-visit summary which is given to the patient or is available via a patient portal. The summary includes:

   i) Current vital signs;

   ii) Relevant health data;
m. The organization provides an after-visit summary of each patient encounter that includes:

iii) Current diagnosis;
iv) Current medications;
v) Important patient instructions;
vi) Patient’s short and long-term goals;
vii) Name of patient’s Provider and; and
viii) PCMH contact information.
Example: After-Visit Summary

<table>
<thead>
<tr>
<th>Vital signs</th>
<th>Medications</th>
<th>Labs</th>
<th>Instructions</th>
<th>Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure: 128/54</td>
<td>Essential Hypertension</td>
<td>Body Mass Index: 34.58</td>
<td>12:30 - Dr. Byrne, Module 4</td>
<td>15:00 - LI/Surg/Pod/Wound Limb/Wed</td>
</tr>
<tr>
<td>Pain: 7</td>
<td>Obesity</td>
<td>Pulse: 66</td>
<td>PROVIDER: JANE</td>
<td>Follow up</td>
</tr>
<tr>
<td>Pulse Oximetry: 96 (Room Air)</td>
<td>Dyslipidemia</td>
<td>Respiration: 18</td>
<td>Cholelithiasis without obstruction</td>
<td>Follow up</td>
</tr>
<tr>
<td></td>
<td>Cholesterol</td>
<td>Temperature: 98.1°F</td>
<td>Smoker</td>
<td>Follow up</td>
</tr>
<tr>
<td></td>
<td>Coronary Arteriosclerosis</td>
<td>Weight: 233.7 lb</td>
<td>Coronary Arteriosclerosis</td>
<td>Follow up</td>
</tr>
</tbody>
</table>

- New Orders From This Visit
- Lab Tests
- Please report to the lab for the following blood tests on the date listed for each test:
  - 01/16/2014
    - Basic Metabolic Panel (Chem 7) Blood Serum
    - Hemoglobin A1c (Lab) Blood
    - Lipid Profile Blood Serum
    - Hepatic Function Panel Blood Serum

- Other Orders
- Return To Clinic In 4 Months
PCMH 6.0 The organization takes steps to reduce unnecessary utilization of services.
PCMH 6.0 The organization takes steps to reduce unnecessary utilization of services.

1) The organization follows a written plan for improving efficiency in the delivery of care, taking steps to prevent utilization of services that increase cost without improving health.
PCMH 6.0 The organization takes steps to reduce unnecessary utilization of services.

2) The plan includes implementation of the following waste reduction initiatives:
   a) Utilizing generic medications
   b) Reducing avoidable patient emergency department visits
   c) Reducing patient hospital re-admissions
PCMH 6.0 The organization takes steps to reduce unnecessary utilization of services.

3) A designated staff member is responsible for collecting and analyzing data through the use of an audit tool designed to yield performance improvement opportunities.

4) Evidence exists of reporting data for follow up as it related to reduced ED use and reduced hospital readmissions for patient who require management and coordination. The is reported quarterly to The Compliance Team.
PCMH 7.0 The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.

Beyond the usual elements, PCMH assesses the best way to interact with a patient and their caregivers or family members.
PCMH 7.0 The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.

1) The organization follows a written policy and procedure for creating Patient-Centered Health Improvement Plans™ (PCHIP™) which addresses the current and future needs of the patient from a whole person perspective focusing on all ages and stages of life.
PCMH 7.0 The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.

The policy describes how the Care Team will:

a) Identify high risk and/or complex patients in the practice.

b) Provide patient communication and education through the formats identified to meet the unique needs of each patient (e.g. written, audio, video, technology-enabled, and/or the use of interpreters).
PCMH 7.0 The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.

The PCHIP™ address the communication needs of the patient:

i) When a physical or mental impairment or learning disability exists,

ii) When English is not the primary language spoken, or

iii) When cultural or religious beliefs may impact the delivery of care.
PCMH 7.0 The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.

c) Perform a needs assessment concerning the patient’s ability to perform the activities of daily living, safety of the home environment, family/caregiver support system, access to transportation and requirements for healthcare services that cannot be met by the organization.
PCMH 7.0 The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.

d) Utilize a questionnaire or interview technique to identify and update the healthcare goal(s) most important from the patient’s perspective. It needs to determine current healthcare limitations and frustrations that interfere with “what matters most” to the patient at this time in their life.
PCMH 7.0 The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.

“What matters most” to the Patient

EXAMPLE: Patient would like to attend grandchild’s wedding, but is unable to do this because she cannot walk long distances without assistance and doesn’t have a wheelchair.
PCMH 7.0 The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.

e) Incorporate end-of-life or palliative care planning when appropriate.
Expected outcomes/prognosis
If I follow the treatment/action plan above, I can expect the following to happen:

- 
- 
- 

Patient signature: 

Provider signature: 

* Data for these sections may be imported from the patient record when this form is used as the basis for an electronic health record template. The following elements should also be incorporated: date created, patient name and identifiers, and provider name.
PCMH 7.0 The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.

2) Evidence exists that all members of the care team are trained to assess and address the needs of the patient from a whole patient perspective, including:

a) The forms of communication and/or resources available to allow for meaningful healthcare interactions and education;

b) Language and cultural competency;
PCMH 7.0 The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.

c) Indicators which prompt social support discussions and referrals.
d) Short and long-term goal planning; and
e) Indicators which prompt end-of-life or palliative care discussions.
1) The organization provides healthcare education and self-management tools when health problems are diagnosed, treatment is ordered, or risks are identified. Education and support includes all appropriate persons, per the direction of the patient, in decision-making regarding care.
PCMH 8.0 The organization provides patient education and self-management tools to patients and their family/caregivers

a) Essential education is always provided to the patient in written form.

*Examples of education include*: written material, audio-visual resources, and referral to individual counseling or group classes.
b) Self-management tools are offered to the patient to encourage compliance.

*Examples of self-management tools include:* medication management plans, goal-oriented TO DOs, and web-based interactive health programs.
Example: Create Self-Management Tools (based on the patient’s desires to participate)

Which of these things may help me feel better?

- Healthy Eating
- Exercise Plan
- Email My Team
- Stress Reduction Group
- Medicine / Pill Box
- Talking
- Journaling
Example: Create Self-Management Tools (based on the patient’s desires to participate)

1. Choose ONE of the things below to work on. Set simple goals and take small steps.
   - Make time for activities I enjoy
   - Reach out to people who can help me
   - Do something kind for someone else each day
   - Eat Healthier
   - Exercise
   - Other: __________________________

2. Choose your confidence level: How sure are you that you can stick to your plan? (If less than 7, consider changing plan)
   - 10 VERY SURE
   - 7 SURE
   - 5 SOMEWHAT SURE
   - 0 NOT SURE AT ALL

3. Fill in the details of your activity:
   What: ______________________________
   ______________________________
   How Much: ______________________________
   ______________________________
   When: ______________________________
   How often: ______________________________
   Where: ______________________________
   ______________________________
   With whom: ______________________________
   ______________________________
   Start Date: ______________________________
   Follow-Up Date: ______________________________
   Best Way to Follow-Up: ______________________________
Example: Create Self-Management Tools (based on the patient’s desires to participate)
PCMH 8.0 The organization provides patient education and self-management tools to patients and their family/caregivers

2) Evidence exists that the patient education provided to patients and their family/caregiver is documented in the patient health record.

EVIDENCE WILL BE ASSESSED THROUGH AN AUDIT OF THE PATIENT HEALTHCARE RECORD
1) The organization has a written process to ensure continuity of care in the follow-up of their patients regarding:

a) Reminder notification system.

b) Missed patient appointments.

c) Requests for medication refills by patients.

d) High-risk medication(s) or in-home treatment(s) that are newly prescribed.
PCMH 9.0 The organization has a written process for follow-up

e) Laboratory or diagnostic results that are abnormal.
f) Referrals and consultations.
g) Preventative care and screening reminders.
h) Care coordination activities.
i) Those patients who frequent the emergency department.
j) Those patients who are discharged from the hospital.
PCMH 9.0 The organization has a written process for follow-up

2) Evidence of follow-up communication with patients exists in the patient healthcare record.

EVIDENCE WILL BE ASSESSED THROUGH AN AUDIT OF THE PATIENT HEALTHCARE RECORD
The organization has a written process for follow-up

- Memorial Hospital Association in Carthage, IL identified 55 frequent flyers to the ED.
- Those 55 were monitored from Jan 1 to March 31, 2017
- Results in April showed only one of those patients had been to the ED.
- How did they manage that?
PCMH 9.0 The organization has a written process for follow-up

• The answer is follow up, follow up and then follow up again.

• Visits to the clinic increased over those three months

• Savings to payers was huge
Quality Improvement

Is your practice providing:

• Better healthcare outcomes for the population served by the organization?
• Better service from the organization?
• Lower costs for the overall care?

QI Review is how to find out...
As you can see... the PCMH model offers a lot to your patients.

QI 1.0 The organization collects data for patient satisfaction and dissatisfaction.

1) The organization ensures a sample of patients receive a patient satisfaction survey. The patient sample size is determined by organizational policy.

2) The results of the patient satisfaction surveys are collected, evaluated and presented at QI/staff meetings. Results are submitted to a national database for outcomes measurement.
QI 1.0 The organization collects data for patient satisfaction and dissatisfaction.

3) The organization has a written policy and procedure to develop and implement corrective action if the results of the patient satisfaction evaluation reveal possible issues.

4) The organization has a written policy for defining, handling, reviewing and resolving complaints.
Q1 1.0 The organization collects data for patient satisfaction and dissatisfaction.

6) When a complaint is received, the organization provides notice to the complainant that the issue is being investigated within the timeframe identified in the organization policy.
QI 2.0 The organization performs an annual evaluation of its written policies for continuous quality improvement. Findings are evaluated to ensure it is following the guiding principles of the Patient-Centered Medical Home model.

EVIDENCE OF COMPLIANCE

1) The organization has written plan describing the continuous quality improvement (CQI) activities of the Patient-Centered Medical Home (PCMH).
QI 2.0 The organization performs an annual evaluation of its written policies for continuous quality improvement. Findings are evaluated to ensure it is following the guiding principles of the Patient-Centered Medical Home model.

The initiatives used to improve the cost-effective use of services, including the following:

i) Follow-up calls/appointments made with patients who visit the emergency department frequently;

ii) Follow-up calls/appointments made with patients following hospital discharge; and

iii) Number of same-day appointments allotted for urgent needs.
f) Compliance with implementing continuity of care measures. The measures address the coordination of care regarding patient appointments, follow-up of provider orders and referrals, and orders for labs and diagnostic testing;
QI 2.0 The organization performs an annual evaluation of its written policies for continuous quality improvement. Findings are evaluated to ensure it is following the guiding principles of the Patient-Centered Medical Home model.

g) Compliance with implementing population specific preventive-health and evidence-based disease management measures (as required by Medicaid or third-party payers (e.g. EPSDT and HEDIS)).
As you can see, the PCMH model offers a lot to your patients. Preventive Health Measures are crucial for maintaining overall health. Here are some of the Preventive Health Measures:

- Mammograms
- Pap Smears
- Colonoscopy
- Immunizations
- PSA
- Fecal Occult Blood
- Tobacco Cessation
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is the child health component of Medicaid. Federal statutes and regulations state that children under age 21 who are enrolled in Medicaid are entitled to EPSDT benefits and that States must cover a broad array of preventive and treatment services.
The organization performs an annual evaluation of its written policies for continuous quality improvement. Findings are evaluated to ensure it is following the guiding principles of the Patient-Centered Medical Home model.

b) Utilize a QI audit tool designed to determine if the plan supports compliance with the guiding principles of PCMH, as follows:

i) Improved patient access;
ii) Team-based care approach;
iii) Care coordination;
iv) Patient-centered Health Improvement Planning™; and
v) Patient follow-up.
QI 2.0 The organization performs an annual evaluation of its written policies for continuous quality improvement. Findings are evaluated to ensure it is following the guiding principles of the Patient-Centered Medical Home model.

c) At least quarterly, analyze data and report findings to leadership.

d) Determine if the QI plan was followed or if changes are needed.
QI 2.0 The organization performs an annual evaluation of its written policies for continuous quality improvement. Findings are evaluated to ensure it is following the guiding principles of the Patient-Centered Medical Home model.

e) Identify performance improvement opportunities.

f) Take corrective action as needed.

g) Communicate changes to the plan throughout the organization.
PCMH Implementation

• Have an initial meeting with your leadership and providers
• Figure out the timeline for implementation
• Have as many staff members as possible attend the webinar for PCMH Quality Standards
• Print the standards and take notes
• Don’t reinvent the wheel
TIPS FOR SUCCESSFUL SURVEYS

• Review the standards as a team to ensure everyone understands the requirements
• Use all of the tools to prepare adequately
• Educate all of your staff, not just management
• Organize all of your hard work in readiness binder for the big day
• Go through the physical plant to ensure readiness
Ideas that work from clinics

• Keep your Medical Assistants in the loop. They need to know exactly what is expected from them each day.
• 90% of the innovations have come from the staff because they are now involved in everything and the frequent meetings.
• Have a morale fund
  • Bring in smoothies
  • Hire a chair massager for the day
  • Rotate who picks the office music each day
  • If you are in a shared savings program, share with them
  • Post testimonials from patients about the importance of preventative medicine.

❖ And the best one: Great medicine is being done outside the patient visit. Mostly in follow up activities