Top 10 Challenging PCMH Standards – Strategies for Attaining and Sustaining PCMH Certification

Linda M Jordan BSRN, MHCM
Field Representative
Ambulatory Care

The Joint Commission
Accreditation
Ambulatory Care

Objectives

1. Describe the PCMH survey process
2. Describe PCMH survey process onsite
3. Discuss strategies for PCMH compliance
4. Present a new resource for assessing your organization's patient-centeredness

The Joint Commission
Accreditation
Ambulatory Care

Survey Process

The PCMH certification review:

- Integrated into your triennial accreditation

  The survey team will be assessing compliance with PCMH elements of performance through out the survey event.

- Conducted as an extension survey (Initial)

  The focus of the survey team will be limited to PCMH elements of performance.

The Joint Commission
Accreditation
Ambulatory Care

Survey Process

- Organization identifies PCMH eligible sites
- Clarify with the survey team PCMH terminology used in your organization
- Clarify the population that the surveyor should expect to see self-management goals
- Surveyors will seek evidence of PCMH compliance through individual patient tracers and interviews of families, providers and staff

Survey Process

After initial PCMH certification, reviews will also focus on:

- Spread of the PCMH to all sites (organizations may choose to excludes sites where they are not the PCP, i.e. school based)
- Data collection on the effectiveness of the PCMH
- Enhanced focus on the patient and staff understanding of PCMH
- Enhanced focus on patient engagement including patient self management goals and involvement in PI

Many organizations find this survey challenging

The Joint Commission
Accreditation
Ambulatory Care

Survey Process – Onsite

- May start where the patient enters the medical home
  - Call Center/Front Desk
  - Assess PCMH communication to patient
  - Assess staff knowledge of PCMH
- Observe the intake of the patient
  - Review data collection and screenings conducted
  - Assess patient knowledge of PCMH
- Observe visit with provider
  - Review SMG and progress
- Observe and assess referral management

Top 10 Most Challenging PCMH Standards

The Joint Commission
Accreditation
Ambulatory Care

#1 Self Management Goals

❑ PC.01.03.01, EP44 - 37%

Surveyors will observe patient visits and conduct chart reviews for evidence that self-management goals are identified and agreed upon with the patient.

Most often observed by surveyors:

- Documentation of patient education and training
- Clinical goals versus patient behavior change goals
- No goals identified
- Scripted goals (same goals in multiple patient records)

The Joint Commission
Accreditation
Ambulatory Care

Compliance Strategies

- Identify who is responsible for working with patients to develop self management goals. Provide training and more training! (video competition)
  - Train to *patient driven* goals
  - Identify patient population – start small and grow
  - Introduce patients to self management goals early in the patient encounter
  - Use SMART goal format – *one goal*
  - Consistent documentation – where in record?
  - Collect data and report – what isn't measured can not be managed

The Joint Commission
Accreditation
Ambulatory Care

#2 Assessing Health Literacy Needs

- **PC.02.03.01, EP 30 – 34%**

Surveyors will be looking for a consistent process for assessing, documenting and communicating a patient's health literacy status, and staff/provider knowledge of the process.

Most often observed by surveyors:

- No health literacy assessment process
- Limited staff/provider knowledge of health literacy
- Learning needs assessment and identification of barriers substituted for health literacy assessment.
- Health literacy assessment status is not transparent to all members of the Interdisciplinary Team

Compliance Strategies

- Select a patient and staff friendly tool – needs to be interactive
- Train all members of the team on what is health literacy
- Identify who is responsible for performing and documenting the assessment.
- Consistent documentation – where in record? Needs to be readily visible to all members of the team
- Determine the what now?
- Determine the frequency of health literacy assessment

#3 Self Management Goals: Patient Progress Documented

- **RC.02.01.01 EP 26 – 15%**

Surveyors will review previous patient visits for evidence of documentation of patient's progress towards self management goals.

Most often observed by surveyors:

- Goals are not followed up on (no documentation)
- No expectations set or process designed to assist patients in tracking and reporting progress
- Goals are hard to find in the record. No consistency as to where the SMGs are documented, hard to document progress

Compliance Strategies

- Determine the who, when and how
  - Who has the responsibility for documenting progress Staff, LIP, Patient or combination
  - When are patient self management goals followed up at next visit, next week, through patient portal?
  - Engage the patient in documenting progress
  - How/where do you document patient's progress towards goal
  - Collect data, analyze and share – what isn't measured can not be managed

#4 Data Collection - Access, Communication, Comprehensiveness

- **PI.01.01.01 EP 30 – 9%**

During the data management session the surveyors will review data collection on patient perception regarding access to care, comprehensive, continuity and coordination of care.

Most often observed by surveyors:

- Organizations are often challenged with collecting data on the comprehensiveness of care.
- Formal patient satisfaction surveys are not always able to accommodate custom questions.
- Organization are not aware that other data collection methods such as patient focus groups can be used (comments need to be analyzed, trended and reported as data).

Compliance Strategies

- Perform a gap analysis of current patient satisfaction tool. Map each PCMH requirement to a question on your tool.

  Examples: 1) Were your referrals followed up on? Were your test results followed up on in a timely manner?(coordination of care) 2) Are you aware of all our services? If we can't meet your needs, were you informed of where to go? (comprehensiveness of care)

  - Engage you primary care association
  - PCMH specific tool
  - Patient focus groups – convert to data

#5 Test Results & Referral Tracking

PC.02.04.05 EP 6 – 8%

Surveyors will review the referral process including tracking of referral status, process for closing referrals, provider involvement in closing referrals. Surveyors may request aged reports on open referrals.

Most often observed by surveyors:

- Lack of process for referral tracking.
- Providers are not knowledgeable of referral status
- Lack of a process to close open referrals
- Thousands of referrals in an open status

Compliance Strategies

- Develop procedures for referral tracking including:
  - Prioritization of referrals by acuity
  - Timelines for working referrals
    - Appointment
    - Follow up with patient and/or referring provider
    - Escalation of contact with noncompliant patient
  - Process for closing referrals, completed and non compliant. Best practice – referral is closed after signature by ordering provider and evidence of discussion with patient
  - Collect data – closed and aging reports

#6 Provide patients with information on PCMH function

- **RI.01.04.03 EP 3 – 8%**

Surveyors might ask for a new patient packet or watch a new patient intake to determine information provided to patients on: selection of PCP, involvement in treatment plan, management of referrals, coordination of care, collaboration with patient selected specialist, and how to communicate with the PCMH about concerns.

Most often observed by surveyors:

- Organization has not included all PCMH requirements in information provided to patients (written, verbal, visual).
- Organization has knowledge gaps as to what information needs to be communicated to the patient.

Compliance Strategies

- Develop PCMH specific communication including:
  - ✓ Selection of a primary care clinician
  - ✓ Involvement in his or her own treatment plan
  - ✓ Management of referrals
  - ✓ Coordination of care
  - ✓ Collaboration with patient-selected clinicians who provide
  - ✓ specialty care or second opinions
  - ✓ Communication with the primary care medical home about health care concerns or other information
- Provide this communication in multiple formats PCMH pamphlet, video in lobby, verbally at registration

The Joint Commission
Accreditation
Ambulatory Care

7 Record of Care

- **RC.02.01.01 EP 25 – 7%**

Surveyors will observe a patient visit or review a closed medical record for evidence of the collection of the following: patient gender, race, ethnicity, family history, work history, smoking status, and BP (ages 3 and above).

Most often observed by surveyors:

- Surveyors have identified gaps in the documentation of smoking status, and blood pressure in children.
- Work history is often documented as occupation versus on the job exposure history that could impact the patient's health status.

The Joint Commission
Accreditation
Ambulatory Care

Compliance Strategies

- Determine where in the *clinical record* you document
  - Gender, race, and ethnicity
  - Family history
  - Work history (work exposure history, not current occupation or retired)
  - Blood pressure (for patients age 3 and older)
  - Smoking status (for patients age 13 and older)
- Conduct chart audits, analyze and report

#8 PCMH Mission, Vision, Goals

- **RI.01.04.03 EP 1 – 6%**

Surveyors might ask for a new patient packet or watch a new patient intake to determine information provided to patients on: the mission, vision, and goals of the PCMH.

Most often observed by surveyors:

- Often organizations have this information but have not reviewed, and if needed, revised their mission, vision and goals to reflect the PCMH.

#9 How the PCMH Functions

- **RI.01.04.03 EP 2 – 5%**

Surveyors might ask for a new patient packet or watch a new patient intake to determine information provided to patients on: the PCMH functions, it's scope of care and it's type of services.

Most often observed by surveyors:

- Organization has not included all PCMH requirements in information provided to patients (written, verbal, visual).
- Organization have knowledge gaps as to what information needs to be communicated to the patient.

#10 Patient's Rights and Responsibilities

- **RI.01.04.03 EP 5 – 5%**

Surveyors might ask for a new patient packet or watch a new patient intake to determine information provided to patients on: Patient rights and responsibilities in the PCMH

Most often observed by surveyors:

- Often organizations have a Patient Rights & Responsibility communication but have not reviewed, and if needed, revised to include patient responsibilities for providing health history and current medications, and participating in self-management activities.

Compliance Strategies

- Develop specific to your PCMH program
  - Mission, Vision and Goals - this may include how your organization provides patient-centered and team-based comprehensive care, a systems-based approach to quality and safety, and enhanced patient access.
  - Information on how your PCMH functions, its scope of care (dental, behavioral health, OB/GYN etc.), and types of services, hours, sites, selection of PCP referral to specialist, 24 hour access, extended hours, patient portal, etc.

Compliance Strategies

- Review and revise your Patient Rights and responsibilities to include patient responsibilities for providing health history, current medications, and participating in self-management activities.

COMMUNICATE, COMMUNICATE, COMMUNICATE

- Communicate in multiple formats:
  PCMH pamphlet, video in lobby, verbally at registration

To fulfill this partnership, we will:

Respect you as an individual

- ✔ Listen to your feelings and questions to help you make decisions and set healthy goals
- ✔ Explain diseases, treatments and results.
- ✔ Keep medical information and records private.

Provide safe and qualified care

- ✔ Provide you with your own primary care provider.
- ✔ Provide clear directions about medicines and treatments.
- ✔ Send you to trusted experts, if needed.
- ✔ End every visit with clear instructions about expectations, treatment goals, medicines and future plans.

Strive to build flexibility to schedule you with your personal physician/provider whenever possible

- ✔ Provide 24-hour phone access to the health care team.

In return, we trust you to:

Be in charge of your health

- ✔ Learn about wellness and preventing disease and make healthy decisions.
- ✔ Be honest and thorough about your history, symptoms and any changes in your health.
- ✔ Tell us what medications you are taking and ask for refills during your office visit.
- ✔ Tell us when you see other doctors, medications they have prescribed and ask them to send a report about your care.
- ✔ Learn what your insurance covers

Be a good patient

- ✔ Take all of your medicine and follow your treatment plan, or tell us if you cannot do so.
- ✔ Respect us as partners in your care.
- ✔ Keep your appointments as scheduled, or call and let us know if you need to cancel.
- ✔ Pay your share of the office visit fee when you are seen in the office.

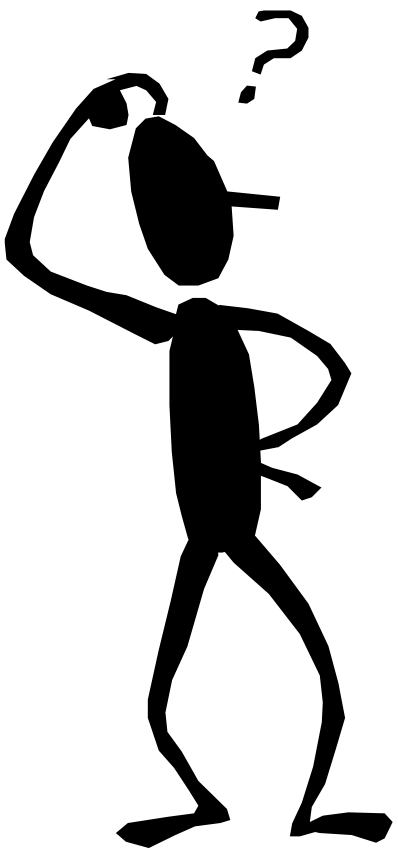
Communicate with us

- ✔ Ask questions, share feelings, be part of your care.
- ✔ Call the office before going to the emergency room
- ✔ Provide us with feedback to improve services.
- ✔ End every visit with a clear understanding of your provider's expectations, treatment goals and future plans.

Observed during the onsite survey…

- During individual tracers patients, families, providers, and staff had difficulty verbalizing what is a patient centered medical home.
- Many patients could not describe how to get a prescription or an appointment after hours.
- Patient access processes often compromised continuity of care.
- Interdisciplinary teams were ill defined, patients could not verbalize who was part of their care team.
- When queried, most patients reported that they were not asked about a self management goal.

Questions



Additional slides on PCMH Assessment Tools follows this presentation.

The Joint Commission
Accreditation
Ambulatory Care

New PCMH Assessment Tool

- Use during planning/design phase
- Use to perform a gap analysis of your PCMH
- It is common for teams to initially believe they are providing more patient-centered care than they actually are
- As your organization progress in quality improvement efforts, you will become more familiar with what an effective system of care involves. You may even notice your scores declining even though you have made improvements this is more likely the result of your better understanding of what optimal patient-centered care looks like

PCMH Assessment Tool

PATIENT CENTERED MEDICAL HOME ASSESSMENT TOOL

Use this tool to "score" your organization's patient centeredness

EMPANELMENT	BEGINNING	DEVELOPING	ADVANCING	APPROACHING
PATIENTS	are not assigned to specific panels ①	are assigned to specific panels but panel assignments are not routinely used for administrative or other purposes ②	are assigned to specific panels and panel assignments are routinely used but mainly for scheduling purposes ③	are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand. ④
PANEL DATA	are not available to assess or manage care for patient populations. ①	are available to assess and manage care for patient populations, but only on an ad hoc basis. ②	are regularly available to assess and manage care for patient populations, but only for a limited number of diseases and risk states. ③	are regularly available to assess and manage care for patient populations, across a comprehensive set of diseases and risk states. ④
REGISTRIES ON INDIVIDUAL PATIENTS	are not available to interdisciplinary teams for pre-visit planning or patient outreach. ①	are available to interdisciplinary teams but are not routinely used for previsit planning or patient outreach. ②	are available to interdisciplinary teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states. ③	are available to interdisciplinary teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states. ④
REPORTS ON OUTCOMES OF CARE	are not routinely available to the interdisciplinary teams ①	are routinely provided as feedback to interdisciplinary teams but not reported externally. ②	are routinely provided as feedback to interdisciplinary teams, and reported externally (e.g. to patients, other teams or external agencies) but with team identities masked. ③	are routinely provided as feedback to interdisciplinary teams, and transparently reported externally to patients, other teams and external agencies. ④

The Joint Commission
Accreditation
Ambulatory Care

PCMH Assessment Tool

PATIENT CENTERED MEDICAL HOME ASSESSMENT TOOL

Use this tool to "score" your organization's patient centeredness

TEAM BASED RELATIONSHIPS	BEGINNING	DEVELOPING	ADVANCING	APPROACHING
PATIENTS ARE ENCOURAGED TO SEE THEIR PANELED PROVIDER	only at the patient's request. ①	by the interdisciplinary team but is not a priority in appointment scheduling. ②	by the interdisciplinary team and is a priority in appointment scheduling, but patients commonly see other providers because of limited availability or other issues. ③	by the interdisciplinary team, is a priority in appointment scheduling, and patients usually see their own provider or practice team. ④
NON-PROVIDER INTERDISCIPLINARY TEAM MEMBERS	play a limited role in providing clinical care. ①	are primarily tasked with managing patient flow and triage ②	provide some clinical services such as assessment or self-management support. ③	perform key clinical service roles that match their abilities and credentials. ④
THE ORGANIZATION	does not have an organized approach to identify or meet the training needs for providers and other staff. ①	routinely assesses training needs and assures that staff are appropriately trained for their roles and responsibilities. ②	routinely assesses training needs, assures that staff are appropriately trained for their roles and responsibilities, and provides some cross training to permit staffing flexibility. ③	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. ④

PCMH Assessment Tool

PATIENT CENTERED MEDICAL HOME ASSESSMENT TOOL

Use this tool to "score" your organization's patient centeredness

PATIENT CENTEREDNESS	BEGINNING	DEVELOPING	ADVANCING	APPROACHING
INVOLVES PATIENTS IN DECISION MAKING AND CARE	is not a priority. ①	is accomplished by provision of patient education materials or referrals to classes. ②	is supported and documented by interdisciplinary teams. ③	is systematically supported by interdisciplinary teams trained in decision making techniques ④
HEALTH LITERACY	is not assessed. ①	is assessed and results are communicated to the interdisciplinary team. ②	is assessed, communicated and patient education is consistent with the patient's health literacy needs. ③	is supported at an organizational level by translation services, hiring multi-lingual staff, and training staff in health literacy and communication techniques assuring that patients know what to do to manage conditions at home. ④
SELF MANAGEMENT SUPPORT	is limited to the distribution of information (pamphlets, booklets). ①	is accomplished by referral to self-management classes or educators. ②	is provided by goal setting and action planning with members of the interdisciplinary team. ③	is provided by members of the interdisciplinary team trained in patient empowerment and self-management tools and techniques. ④

PCMH Assessment Tool

PATIENT CENTERED MEDICAL HOME ASSESSMENT TOOL

Use this tool to "score" your organization's patient centeredness

ENHANCED ACCESS	BEGINNING	DEVELOPING	ADVANCING	APPROACHING
APPOINTMENT SYSTEMS	are limited to a single office visit type. ①	provide some flexibility in scheduling different visit lengths. ②	provide flexibility and include capacity for same day visits. ③	are flexible and can accommodate customized visit lengths, same day visits, scheduled follow-up and multiple provider visits. ④
CONTACTING THE TEAM DURING CLINIC HOURS	is difficult ①	relies on the team's ability to respond to telephone messages. ②	is accomplished by staff responding by telephone within the same day. ③	is accomplished by providing a patient a choice between email and phone interaction, utilizing systems which are monitored for timeliness. ④
AFTER HOURS ACCESS	is not available or limited to an answering machine. ①	is available from a coverage arrangement without a standardized communication protocol back to the practice for urgent problems. ②	is provided by coverage arrangement that shares necessary patient data and provides a summary to the practice. ③	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. ④

The Joint Commission
Accreditation
Ambulatory Care

PCMH Assessment Tool

PATIENT CENTERED MEDICAL HOME ASSESSMENT TOOL

Use this tool to "score" your organization's patient centeredness

CARE COORDINATION	BEGINNING	DEVELOPING	ADVANCING	APPROACHING
MEDICAL AND SURGICAL SPECIALITY SERVICES	are difficult to obtain reliably. ①	are available from community specialists but are neither timely nor convenient. ②	are available from community specialists and are generally timely and convenient. ③	are readily available from specialists who are members of the care team or who work in an organization with which the organization has a referral protocol or agreement. ④
BEHAVORIAL HEALTH SERVICES	are difficult to obtain reliably. ①	are available from mental health specialists but are neither timely nor convenient. ②	are available from community specialists and are generally timely and convenient. ③	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. ④
PATIENTS IN NEED OF SPECIALITY CARE OR COMMUNITY BASED RESOURCES	cannot reliably obtain needed referrals to partners with whom the practice has a relationship. ①	obtain needed referrals to partners with whom the organization has a relationship. ②	obtain needed referrals to partners with whom the organization has a relationship and relevant information is communicated in advance. ③	obtain needed referrals to partners with whom the organization has a relationship, relevant information is communicated in advance, and timely follow-up after the visit occurs. ④

The Joint Commission
Accreditation
Ambulatory Care

PCMH Assessment Tool

PATIENT CENTERED MEDICAL HOME ASSESSMENT TOOL

Use this tool to "score" your organization's patient centeredness

CARE COORDINATION	BEGINNING	DEVELOPING	ADVANCING	APPROACHING
FOLLOW UP BY THE INTERDISCIPLINARY TEAM WITH PATIENTS SEEN IN THE EMERGENCY ROOM OR HOSPITAL	generally, does not occur because the information is not available to the interdisciplinary team ①	occurs only if the ER or hospital alerts the interdisciplinary team. ②	occurs because the interdisciplinary team makes proactive efforts to identify patients. ③	is done routinely because the interdisciplinary team has arrangements in place with the ER and hospital to both track these patients and ensure that follow-up is completed within a few days. ④
LINKING PATIENTS TO SUPPORTIVE COMMUNITY BASED RESOURCES	is not done systematically ①	is limited to providing patients a list of identified community resources in an accessible format. ②	is accomplished through a designated staff person or resource responsible for connecting patients with community resources. ③	is accomplished through active coordination between the organization, community service agencies and patients and accomplished by a designated staff person. ④
TEST RESULTS AND CARE PLANS	are not routinely tracked or communicated to patients. ①	are tracked and communicated to patients based on an ad hoc approach, such as when they present for appointments. ②	are systematically tracked and results are communicated to patients in a way that is convenient to the organization. ③	are systematically tracked and results are communicated to patients in a variety of ways that are convenient to patients and align with patient preferences. ④

The Joint Commission
Accreditation
Ambulatory Care

PCMH Assessment Tool

PATIENT CENTERED MEDICAL HOME ASSESSMENT TOOL

Use this tool to "score" your organization's patient centeredness

EVIDENCE BASED CARE	BEGINNING	DEVELOPING	ADVANCING	APPROACHING
COMPREHENSIVE GUIDELINE-BASED INFORMATION ON PREVENTION OR CHRONIC DISEASE TREATMENT	is not readily available. ①	is available but does not influence care. ②	is available to the team and is integrated into care protocols and/or reminders. ③	guides the creation of tailored, individual-level data that is available at the time of the visit. ④
VISITS	largely focus on acute problems of patient. ①	are organized around acute problems but with attention to ongoing illness and prevention needs if time permits. ②	are organized around acute problems but with attention to ongoing illness and prevention needs if time permits. The organization also uses subpopulation reports to proactively call groups of patients in for planned care visits. ③	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. ④
SELF MANAGEMENT GOALS	are not routinely developed or recorded. ①	are developed and recorded but reflect providers' priorities only. ②	are developed collaboratively with patients and families and include self-management and clinical goals, but they are not routinely recorded or used to guide subsequent care. ③	are developed collaboratively, with patients and families and include self-management and clinical management goals, routinely recorded and guide care at every subsequent point of service. ④

The Joint Commission
Accreditation
Ambulatory Care

PCMH Assessment Tool

PATIENT CENTERED MEDICAL HOME ASSESSMENT TOOL

Use this tool to "score" your organization's patient centeredness

WHAT DOES YOUR SCORE MEAN?

Between 22 and 33 = limited support for patient-centered care

Between 34 and 55 = basic support for patient-centered care

Between 56 and 77 = reasonably good support for patient-centered care

Between 77 and 88 = fully developed patient-centered care

PCMH Assessment Tool Adapted from: Safety Net Medical Home Initiative
2010 MacColl Institute for Healthcare Innovation, Group Health Cooperative

The Joint Commission
Accreditation
Ambulatory Care

The Joint Commission Disclaimer

- Slides are current as of 8/26/2019. The Joint Commission reserves the right to change the content of the information, as appropriate.
- These slides are only meant to be cue points, which were expounded upon verbally by the original presenter and are not meant to be comprehensive statements of standards interpretation or represent all the content of the presentation. Thus, care should be exercised in interpreting Joint Commission requirements based solely on the content of these slides.
- These slides are copyrighted and may not be further used, shared or distributed without permission of the original presenter or The Joint Commission.