



March 21, 2011

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Marianne Fazen, PhD
Board Chairperson

Alan P. Spielman
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The Honorable Theresa Geratana
The Honorable Elizabeth Ritter
Chairwomen, Joint Committee on Public Health
Connecticut General Assembly

Dear Chairwoman Ritter and Chairwoman Geratana,

The American Accreditation Healthcare Commission/URAC (URAC) is writing with respect to Connecticut House Bill (HB) 6305 which establishes the SustiNet health plan and encourages the use of patient-centered medical homes, promoting quality and cost-efficient payment and delivery systems. URAC is a nationally recognized managed health care accreditation organization with over 25 accreditation and certification programs across the health care spectrum and offers additional resources such as the URAC Patient Centered Health Care Home (PCHCH) Program Toolkit (attached). As states and public purchasers look at issues related to patient centered care, URAC's comprehensive toolkit can serve as a helpful resource.

URAC's PCHCH Program Toolkit was developed in 2010 with the guidance of an expert advisory committee on medical homes. The Program includes three toolkits for physician practices to use as they implement a patient-centered health care home model of care. The toolkits are based on a set of principles governing the provision of patient-centered care and function as another resource to help health plans and providers evaluate the patient-centeredness of their respective networks and practices.

As you know, Section 11(c)(1) of HB 6305 requires providers to meet eligibility criteria in order to receive reimbursements as a patient-centered medical home. URAC encourages the Legislature to identify the URAC PCHCH Program Toolkit as a resource in the development of criteria for patient-centered medical homes.

Overview of URAC

URAC is an independent, nonprofit organization whose mission is to promote continuous improvement in the quality and efficiency of health care management through the processes of accreditation, education and measurement. Our strategic priorities are to:

- Enhance Continuity of Care;
- Encourage Transparency: Cost & Performance/Quality Data;
- Engage Consumers in their Health Care Management;
- Enhance Operational Management Effectiveness; and
- Engender Support for Evidence-Based Decision-Making

To support these goals, our Board of Directors represents the full spectrum of stakeholders interested in our health care system, including consumers, employers, health care providers, health insurers, purchasers, workers' compensation carriers and regulators.

Incorporated in 1990, URAC pioneered utilization management accreditation by creating a nationally recognized set of standards to ensure accountability in managed care

determinations of medical necessity. As the health care industry evolves, URAC continues to address emerging issues: we now offer over 25 accreditation and certification programs across the health care spectrum (i.e., Case Management, Claims Processing, Consumer Education and Support, Core Organizational Quality, Credentials Verification Organization, Comprehensive Wellness, Disease Management, Drug Therapy Management, Health Call Center, Health Content Provider, Health Network, Health Plan, Health Provider Credentialing, Health Utilization Management, Health Website, HIPAA Privacy, HIPAA Security, Independent Review Organization, Mail Service Pharmacy, Medicare Advantage Deeming, Pharmacy Benefit Management, Specialty Pharmacy, Workers' Compensation Utilization Management, Provider Performance Measurement and Public Reporting, Uniform External Review, Vendor Certification, and Pharmacy Benefit Management for Workers Compensation and Property and Casualty).

Many states have found URAC accreditation standards helpful in ensuring that managed care plans and other health care organizations are meeting quality benchmarks. Forty-six states and the District of Columbia currently reference one or more URAC accreditation programs in their statutes, regulations, agency publications or contracts, making URAC the most recognized national managed care accreditation body at the state level.

At the federal level, four federal agencies recognize URAC accreditation. The Centers for Medicare and Medicaid Services (CMS) recognize URAC Medicare Advantage Health Plan Accreditation for the Medicare Advantage (formerly Medicare+Choice) Program; CMS' Center for Medicaid State Operations recognizes the comparability of URAC Health Plan Standards with the federal Medicaid Managed Care Regulations; the Office of Personnel Management recognizes all URAC accreditation programs under the Federal Employee Health Benefits Program; TRICARE/Military Health System recognizes URAC Health Network, Disease Management, Health Utilization Management and Case Management Accreditations; and the Department of Veterans' Affairs recognizes URAC's Health Call Center, Independent Review Organization, and Health Utilization Management Accreditations.

URAC Standards: Establishing Quality Benchmarks

URAC accreditation serves as a symbol of excellence in the health care industry, promoting prevailing industry standards and consumer protections. In the rapidly evolving field of health care, URAC standards are developed through a dynamic process that identifies best practices and promotes high quality performance measurement. All stakeholders in the health care arena actively participate with URAC in developing these quality benchmarks through an inclusive process that incorporates an opportunity for public comment.

URAC's standards development process begins with a period of careful research, debate and discussion among stakeholders. An initial set of standards is then proposed and made available for a public comment and review. URAC's advisory committees review the submitted comments, make appropriate changes, and the draft standards are then beta tested with a discrete group of companies in order to ensure that they work in practice. After beta testing, the standards may be modified again, and then they are forwarded to URAC's Board of Directors for consideration and approval. URAC revises its standards through this process at least every three years.

URAC Patient Centered Health Care Home Program Toolkit

In 2010, URAC released the Patient Centered Health Care Home (PCHCH) Program Toolkit to educate and guide health care practices, health plans, insurers, and pilot programs on how to transform practices into truly patient centered health care homes. As you may know, a PCHCH is a quality driven, interdisciplinary clinician-led team approach to delivering and coordinating care that puts patients, family members, and personal caregivers at the center of all decisions concerning the patient's health and wellness. A PCHCH provides comprehensive and individualized access to physical health, behavioral health, and supportive community and social services. The URAC PCHCH Toolkit is an educational resource that is flexible enough to be adapted to each practice. The Toolkit provides self-paced steps to assist in the transformation of practice culture, infrastructure, and operations needed to become a PCHCH.

URAC's PCHCH Program Toolkit includes:

- **Practice Assessment Standards, Interpretive Guidance and Checklist** – Enabling practices to self-assess themselves in the following key areas:
 - Core Quality Care Management
 - Patient-Centered Operations Management
 - Access and Communications
 - Testing and Referrals
 - Care Management and Coordination
 - Advanced Electronic Capabilities
 - Performance Reporting and Improvement
- **Performance Measures Information Resource** – Identifying measures directly pertinent to the provision of high quality patient centered care.
- **Survey Information Resource** – Providing an overview and recommendation of publicly available patient experience surveys.

Conclusion

URAC appreciates this opportunity to inform the Connecticut legislature about the URAC PCHCH Program Toolkit as it considers House Bill 6305. We hope that the Toolkit will be helpful to any future consideration of measures related to medical homes. In addition to the attached Toolkit, additional resources are available through the Policymaker Portal on the URAC website (<http://www.urac.org/policyMakers/resources/>). Please do not hesitate to contact me (mosman@urac.org, 202/962-8838) or URAC Government Relations Specialist Justin Peters (jpeters@urac.org, 202/962-8832) if URAC can provide any further assistance.

Thank you for your consideration.

Best Regards,



Mara Osman, J.D.
Government Relations Director

CC: Members of the Joint Committee on Human Services

Attachments: URAC Patient Centered Health Care Home Program Toolkit (Version 1.0,
2010)
URAC Patient Centered Health Care Home Program Toolkit Factsheet



PCHCH PROGRAM PRACTICE ASSESSMENT TOOLKIT, VERSION 1.0

CORE QUALITY CARE MANAGEMENT

ORGANIZATIONAL CORE (COR)

- COR-1: Organizational Structure
- COR-2: Organization Documents
- COR-3: Staff Qualifications - Job Descriptions
- COR-4: Staff Training Requirements
- COR-5: Staff Teamwork Optimization and Job Satisfaction
- COR-6: Patient Empowerment and Engagement
- COR-7: Patient Satisfaction
- COR-8: Patient Safety Mechanism
- COR-9: Optimizing Care - Awareness of Clinical Advances
- COR-10: Optimizing Care Value
- COR-11: Provision of Cost/Benefit Information and Decision Aids
- COR-12: Establishing and Utilizing a Referral Network
- COR-13: Health Literacy
- COR-14: Established Patient Rights and Responsibilities

PATIENT-CENTERED OPERATIONS MANAGEMENT

PARTNERSHIP AGREEMENT (PA)

- PA-1: Partnership Outreach and Engagement
- PA-2: Partnership Agreement

PATIENT REGISTRY (PR)

- PR-1: Registry Implementation
- PR-2: Registry – Patient Information
- PR-3: Registry Supports Identifying Gaps in Care

ACCESS AND COMMUNICATIONS

ACCESS TO SERVICES (ATS)

- ATS-1: Patient Access to Services and Information
- ATS-2: Enhancing Patient Access to Services
- ATS-3: Ensure Equitable Access and Services

COMMUNITY SERVICES & RESOURCES (CSR)

- CSR-1: Comprehensive Services and Resources
- CSR-2: Collaboration with Community Resources
- CSR-3: Community Resource Referrals
- CSR-4: Tracking and Follow-Up of Community Resource Referrals

TESTING AND REFERRALS

MANAGING TESTS AND RESULTS (MTR)

- MTR-1: Documented Process for Ordering Tests
- MTR-2: Documented Process for Managing Test Results

REFERRAL PROCESS (RP)

- RP-1: Referrals Process
- RP-2: Referral Information
- RP-3: Specialist Appointments
- RP-4: Electronic-Based Tools for Referrals
- RP-5: Track and Follow-Up on Referral



PCHCH PROGRAM PRACTICE ASSESSMENT TOOLKIT, VERSION 1.0

CARE MANAGEMENT AND COORDINATION

WELLNESS AND HEALTH PROMOTION (WHP)

- WHP-1: Promoting Wellness
- WHP-2: Wellness and Prevention Services
- WHP-3: Comprehensive Health Risk Assessment
- WHP-4: Wellness Information and Materials
- WHP-5: Documentation of Resources
- WHP-6: Secondary Prevention Program
- WHP-7: Collection of Wellness-Related Health Encounter Patient Data
- WHP-8: Patient Reminders

INDIVIDUAL CARE MANAGEMENT (ICM)

- ICM-1: Care Management – Integrated Team
- ICM-2: Ongoing Care Management Protocols –All Patients
- ICM-3: Informed Decision-Making with Patients
- ICM-4: Chronic Condition – Care Management
- ICM-5: Self-Management
- ICM-6: Chronic Condition – Appointments
- ICM-7: Chronic Condition – Follow-Up
- ICM-8: Medication Review and Reconciliation

COORDINATION OF CARE (COC)

- COC-1: Coordination of Care
- COC-2: Health Record Information Exchange and Alerts
- COC-3: Written Transition Plans
- COC-4: Coordination of Care with Non-PCHCH Care Management
- COC-5: Coordinating Care Site Transitions
- COC-6: Coordination of Care Program for All Chronic Conditions
- COC-7: Coordination of Care Program for All
- COC-8: Appropriate Use of Clinical Guidelines

SELF-MANAGEMENT SUPPORT (SMS)

- SMS-1: Chronic Condition – Self-Management Support and Implementation
- SMS-2: Assessment of Patient Self-Care Capabilities
- SMS-3: Self-Management Support for All Patients

ADVANCED ELECTRONIC CAPABILITIES

ELECTRONIC PATIENT REGISTRY (EPR)

- EPR-1: Electronic Registry
- EPR-2: Registry Function

ELECTRONIC COMMUNICATIONS PORTAL (ECP)

- ECP-1: Electronic Communications Portal – Patient Self-Services
- ECP-2: Bidirectional Electronic Communications Portal
- ECP-3: Electronic Communications Portal Interactions
- ECP-4: Electronic Communications Portal Review
- ECP-5: Electronic Communications Portal Disclosures
- ECP-6: Electronic Communications Portal – Opt-in or Opt-out
- ECP-7: Evaluation of Electronic Communications Portal

ELECTRONIC PRESCRIBING AND DISPENSING (EPD)

- EPD-1: Electronic Prescribing System
- EPD-2: Electronic Prescribing Utilized
- EPD-3: Dispensing Medication
- EPD-4: Electronic Prescribing Notification
- EPD-5: Electronic Prescription Request
- EPD-6: Electronic Medication Review and Reconciliation



PCHCH PROGRAM PRACTICE ASSESSMENT TOOLKIT, VERSION 1.0

ELECTRONIC HEALTH RECORDS (EHR)

EHR-1: Electronic Health Record

EHR-2: Electronic Health Record Integration

EHR-3: Basic Electronic Health Record Functions

EHR-4: Advanced Electronic Health Record Functions

PERFORMANCE REPORTING AND IMPROVEMENT

PERFORMANCE REPORTING (PRT)

PRT-1: Analysis of Performance Reporting Data

PRT-2: Performance Reporting – Tracking and Reporting

PRT-3: Levels of Performance Reporting

PRT-4: Performance Reporting Validation

PRT-5: Performance Reporting – Trends Analysis and Action

PRT-6: Performance Reporting

PRT-7: Performance Reporting Transparency



**Patient Centered Health Care Home
Program Toolkit, Version 1.0**

STANDARDS ONLY

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Copyright for PCHCH Program Toolkit – Standards Only

Patient Centered Health Care Home Program Toolkit, Version 1.0, December 2010.

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Message from URAC

URAC Overview

Quality-based operations are the centerpiece of any company doing business in today's health care system. Quality improvement activities promote a wide range of benefits such as increasing operational efficiencies, reducing business risks, and improving patient health outcomes. However, health care professionals must identify and implement a quality improvement methodology that really works for their particular business model and health care setting.

URAC, an independent, nonprofit organization, is well-known as a leader in promoting health care quality through its accreditation, education, and measures programs. Through its broad-based governance structure and an inclusive standards development process, URAC ensures that all stakeholders are represented in establishing meaningful quality standards for the entire health care industry. These volunteers represent every sector of the industry, including purchasers, regulators, consumers, providers and industry representatives. Now in its 21st year of operation, URAC offers 27 different accreditation and certification programs and has issued more than 10,000 accreditation certificates to companies operating in all 50 states and internationally. URAC is also recognized by 46 states and five federal agencies.

In 2009 URAC embarked on a mission to develop a truly patient centered health care home (PCHCH) that would address the integration of family, caregivers, patients, and care coordination in the delivery of quality health care to patients. To address the evolution of practices to becoming a patient centered health care home, URAC developed the Patient Centered Health Care Home (PCHCH) Program Toolkit and related Information Resources. Multi-stakeholder advisory committees were convened for the development of the practice assessment toolkit, and survey and measures information resources. Public comment was sought to assure industry representation and commentary for the development of the toolkit and information resources. The PCHCH Program Toolkit and related Information Resources identify key standards and provide interpretative guidance on using a step-wise approach to becoming a truly patient centered health care home. The toolkit provides a framework for practices and sponsoring organizations to evaluate current status and progress towards becoming a PCHCH.

URAC continues its development of resources, educational offerings and programs to support the Patient Centered Health Care Home. Check URAC's website at www.urac.org/healthcare for additional information on the PCHCH program.

Acknowledgement

URAC acknowledges that portions of this Toolkit are adapted from the Blue Cross Blue Shield of Michigan Patient Centered Medical Home Initiatives.

Introduction to URAC's Patient Centered Health Care Home Program Toolkit

Overview and Goals

URAC has developed its Patient Centered Health Care Home Program Toolkit to educate and guide health care practices, and/or their sponsoring health plans, insurers, and pilot programs, on how to transform themselves into a truly patient centered health care home (PCHCH). The goal of this toolkit is to help these groups better understand what constitutes a fully functioning PCHCH, and support practices in their PCHCH transformation journey, by using an educational, step-wise approach, with objective benchmarks for assessing progress while promoting optimal continuity and quality of care for the patient.

Based on the latest research, URAC's PCHCH Program Toolkit leads the way in identifying and addressing the key essential standards needed to become a truly patient centered health care home, including:

1. Greatly enhanced patient access to their health care team;
2. A personal relationship between patients, families, and caregivers and their assigned and accountable health care team members;
3. Shared decision-making that actively engages the patient and respects his/her personal health goals cultural needs;
4. Direct and ongoing health care team oversight and coordination of all patient care, as well as referral to supportive social and community resources;
5. Smooth and timely health care transitions and follow-up; and
6. Active provision of the highest quality care possible, elimination of health care disparities, and reduction of care costs by minimization of duplication, reduction of medical errors and unnecessary utilization, and guiding patients to clinically appropriate high value health care.

Definition of a Patient Centered Health Care Home

URAC defines a PCHCH as follows:

A **Patient Centered Health Care Home** (PCHCH) is a quality driven, interdisciplinary clinician led team approach to delivering and coordinating care that puts patients, family members, and personal caregivers at the center of all decisions concerning the patient's health and wellness. A PCHCH provides comprehensive and individualized access to physical health, behavioral health, and supportive community and social services, ensuring patients receive the right care in the right setting at the right time. A PCHCH also:

- Utilizes population-based tools to support and monitor wellness and care goals for each patient, aimed at preventing illness and improving individual well being, clinical outcomes and quality of life;
- Empowers patients and their families/caregivers to be active participants in their care, through patient-friendly education and informed shared decision-making that is based on cooperation, trust, and respect for each individual's health care knowledge and health literacy, values, beliefs, and cultural background;

- Is accountable for coordinating, providing, and monitoring a patient's needs, including prevention, wellness, medical and behavioral health treatment, care transitions, and social and community services through the creation of an appropriate individual plan of care;
- Optimizes value for patients, payers, and society at large, driven by a commitment to care excellence and customer service;
- Utilizes team based care delivery, with the team sharing responsibility for promoting the overall health, function, and well being of the patient; and
- Provides a rewarding place to work, offering a high level of job training and satisfaction for all members of the team allowing team members to optimize their training and experience.

Guiding Principles for a Patient Centered Health Care Home

URAC designed its PCHCH Program Toolkit around the following **Guiding Principles**:

PRINCIPLE 1 – PATIENT CENTERED CARE TEAM CULTURE

The PCHCH's operational culture successfully supports a patient-friendly, patient-centered care team approach to care.

PRINCIPLE 2 – APPROPRIATE ACCESS TO CARE

The PCHCH strives to provide patients with prompt and convenient access to the best care and to bring about optimal outcomes.

PRINCIPLE 3 – INDIVIDUALIZED CARE PLANNING

The PCHCH works in a close and cooperative partnership with patients, and family and personal caregivers to establish a plan of care that reflects a high level of shared decision-making and addresses the patient's current and future needs.

PRINCIPLE 4 – EFFECTIVE AND TIMELY CARE COORDINATION AND FOLLOW-UP

The PCHCH is accountable for all care provided to the patient, and displays the ability to proactively anticipate, plan, coordinate, monitor and follow-up on its patients' continuity of care and community and social needs, utilizing health information technology and population-based health tools where possible.

PRINCIPLE 5 – ELIMINATING HEALTH CARE DISPARITIES

The PCHCH is committed to eliminating disparities in care access and delivery, leading to better health care outcomes.

PRINCIPLE 6 – PROMOTING CARE QUALITY AND CONTINUOUS QUALITY IMPROVEMENT

The PCHCH is committed to providing high quality care for its patients, utilizing evidence-based care guidelines and measuring and tracking care outcomes to drive continuous quality improvement.

PRINCIPLE 7 – STEWARDING THE COST-EFFECTIVE USE OF HEALTH CARE RESOURCES

The PCHCH evaluates the risks and benefits of care options for each patient, striving to optimize the clinical impact for the patient while giving due consideration to the cost impact for the patient, family, and society at large.

PRINCIPLE 8 – EXCELLENCE IN CUSTOMER SERVICE

The PCHCH strives to provide the best care experience for its patients, surveying patients on their experience and satisfaction, and actively using this information to continuously improve the customer experience.

PRINCIPLE 9 – COMMITMENT TO TRANSPARENCY

The PCHCH generates validated data on its clinical outcomes, its ability to reduce unnecessary utilization and costs, and its patient satisfaction levels for public reporting purposes, evaluation of the PCHCH, and internal quality improvement.

PRINCIPLE 10 – PCHCH INFRASTRUCTURE AND OPERATIONS

The PCHCH's care team composition, organizational, and operational infrastructure, operational policies, and workflow protocols, clearly delineate individual staff responsibilities, internal training requirements, work in harmony to successfully support effective and timely delivery of PCHCH services to the population served.

PCHCH Practice Assessment Toolkit Overview

The Practice Assessment Toolkit is the heart of the PCHCH Program Toolkit, helping practices and third party sponsoring organizations learn the essential standards of what constitutes a PCHCH and providing 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 guides a health care practice's progress, which can be tracked and documented, towards becoming a fully functional PCHCH. This Practice Assessment Toolkit can also be used by a sponsoring third party organization to assess a practice's progress towards becoming a PCHCH.

The Practice Assessment Toolkit is not included in the standards only version.

Using the Practice Assessment Toolkit

The Practice Assessment Toolkit identifies a set of 86 PCHCH key operational standards which practices can use to guide and track their progress in transforming themselves into a PCHCH. Transformation into a PCHCH is seen as a step-wise journey along a continuum, as practices become increasingly patient-centered in terms of internal culture, training, care team approach, enhanced care access, communication and coordination, patient engagement and shared decision making, and installing supportive policies, systems and infrastructure.

As shown below, the Practice Assessment Toolkit's 86 standards are organized into 7 modules (bold, underlined) and 16 standard groups (abbreviations shown).

PCHCH Practice Assessment Toolkit Modules and Standards Groups

Core Quality Care Management

- Organizational Core (COR)

Patient-Centered Operations Management

- Partnership Agreement (PA)
- Patient Registry (PR)

Access and Communications

- Access to Services (ATS)
- Communication Services & Resources (CSR)

Testing and Referrals

- Managing Tests and Results (MTR)
- Referral Process (RP)

Care Management and Coordination

- Wellness and Health Promotion (WHP)
- Individual Care Management (ICM)
- Coordination of Care (COC)
- Self-Management Support (SMS)

Advanced Electronic Capabilities

- Electronic Patient Registry (EPR)
- Electronic Communications Portal (ECP)
- Electronic Prescribing and Distribution (EPD)
- Electronic Health Records (EHR)

Performance Reporting and Improvement

- Performance Reporting (PRT)

PCHCH Program Practice Assessment Toolkit

CORE QUALITY CARE MANAGEMENT

PCHCH ORGANIZATIONAL CORE (COR)

Goal is to establish basic organizational, cultural, training, systems, and operational requirements which support a successful PCHCH model of patient engagement and care delivery and follow-up.

Standard COR-1: Organizational Structure

The *Practice* has a clearly defined organizational structure outlining direct and indirect oversight responsibility throughout the organization and identifies a designated facilitator in three (3) areas:

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

Standard COR-2: Organization Documents

The *Practice's* documents address:

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

Standard COR-3: Staff Qualifications - Job Descriptions

The *Practice* has written job descriptions for the key coordinator and staff that address requirements pertinent to the:

- (a) Scope of the positions' roles and responsibilities, including required education and training;
- (b) Professional competencies including licensure/certification requirements; **and**
- (c) Professional experience.

Standard COR-4: Staff Training Requirements

The *Practice* establishes ongoing training programs and initial orientation, which is documented and includes the following, if applicable:

- (a) Approach to patient engagement and shared decision-making;
- (b) Team member roles and responsibilities;
- (c) PCHCH culture and provision of courteous customer service in a culturally-appropriate manner;
- (d) Confidentiality and proper handling of individually identifiable health information;
- (e) Ethical training that includes prohibition of discrimination;
- (f) Maintenance of professional competency; **and**

(g) Standards of the PCHCH that have been implemented.

Standard COR-5: Staff Teamwork Optimization and Job Satisfaction

The *Practice* ensures the 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.

Standard COR-6: Patient Empowerment and Engagement

PCHCH ensures patients/caregivers are educated and actively engaged in their rights, roles and responsibilities in the shared decision-making process, are provided with:

- (a) Consumer friendly, culturally/linguistically appropriate, educational information on their condition(s) and health care needs, as well as educational decision aids; **and**
- (b) Information about how to be actively engaged in their care.

Standard COR-7: Patient Satisfaction The *Practice* seeks feedback from patients/families/caregivers on all aspects of its operation, and actively utilizes results to ensure an optimal patient experience.

Standard COR-8: Patient Safety Mechanism

The *Practice* has a patient safety mechanism in place to respond to situations that pose an immediate threat to the health and safety of its patients.

Standard COR-9: Optimizing Care - Awareness of Clinical Advances

The *Practice* maintains awareness of the latest clinical advances in health care, and disseminates this information on a regular basis to members of care team.

Standard COR-10: Optimizing Care Value

The *Practice* employs written policies and protocols to review cost options with the *patient*, given competing therapeutically-comparable diagnostic procedures and treatment options available for a particular clinical condition.

Standard COR-11: Provision of Cost/Benefit Information and Decision Aids

The *Practice* will provide patient-friendly cost/benefit educational information and decision aids to patients/caregivers to assist in shared decision-making on:

- (a) Selecting diagnostic procedures;
- (b) Treatments;
- (c) Potential outcomes in terms of cost benefit; **and**
- (d) Impact on function and quality of life.

Standard COR-12: Establishing and Utilizing a Referral Network

The *Practice* establishes a network of specialists who collaborate and share information with the PCHCH team and:

- (a) Demonstrate cost-effective clinical expertise;
- (b) Maintain high care standards;
- (c) Provide patient-centric care; and
- (d) Provide timely interactive communications on patient status and clinical data with the PCHCH.

Standard COR-13: Health Literacy

The PCHCH implements written policies and/or documented procedures to provide information that:

- (a) Conforms to the literacy levels of the patients, as practicable;
- (b) Helps patients be aware of what effect a health care decision may have for their daily lives;
- (c) Presents and delivers information in a way that is appropriate to the diversity of the patient population, including:
 - (i) Literacy levels;
 - (ii) Language differences;
 - (iii) Cultural differences; **and**
 - (iv) Cognitive and/or physical impairments.

Standard COR-14: Established Patient Rights and Responsibilities

Upon enrollment of a *patient*, the *Practice* conveys information on rights and responsibilities to *patients* including:

- (a) The right to know about philosophy and characteristics of the *Practice*;
- (b) The right to have *personal health information* shared with the Practice only in accordance with state and federal law;
- (c) The right to identify the *staff* member of the Practice and their job title, and to speak with a supervisor of the *staff* member if requested;
- (d) The right to receive current information from the Practice;
- (e) The right to decline, revoke consent or disenroll at any point in time from the PCHCH;
- (f) The responsibility to submit any forms that are necessary, to the extent required by law;
- (g) The responsibility to give accurate clinical and contact information and to notify the Practice of changes in this information; **and**
- (h) The responsibility to notify their treating *clinician(s)* of their participation in the PCHCH, if applicable.

PATIENT-CENTERED OPERATIONS MANAGEMENT

PARTNERSHIP AGREEMENT (PA)

Goal is to expand practice and patient awareness of, and commitment to, the PCHCH model, and strengthen the bond between patients and their care giving team.

Standard PA-1: Partnership Outreach and Engagement

The *Practice* has a mechanism in place to:

- (a) Engage patients/care giver in the PCHCH:
 - (i) Concept;
 - (ii) Advantages; **and**
 - (iii) Patient and team roles/responsibilities; **and**
- (b) Provide patient communication tools.

Standard PA-2: Partnership Agreement

The *Practice* establishes patient-clinician partnership agreements that:

- (a) Ensure the patient/caregiver is able to verbalize their understanding of the patient-clinician agreement prior to executing the patient-clinician agreement; **and**
- (b) The agreements are implemented and documented in the patient's health record.

PATIENT REGISTRY (PR)

Goal is to establish a comprehensive patient registry to optimally manage a population of patients, improve health status, and ultimately lower health care costs. Registry allows Practice to identify care gaps and needed preventive, wellness, and follow-up services.

Standard PR-1: Registry Implementation

The *Practice* uses a registry for its patients which identify:

- (a) High prevalence and/or high-risk conditions;
- (b) Complex conditions;
- (c) Behavioral health conditions; **and**
- (d) Multiple social service needs.

Standard PR-2: Registry – Patient Information

The *Practice* registry has been implemented and includes:

- (a) Patient contact information;
- (b) Demographic information;
- (c) Care guidelines; **and**
- (d) Pertinent clinical information.

Standard PR-3: Registry Supports Identifying Gaps in Care

The *Practice* advanced registry has been implemented and includes:

- (a) All the elements in PR2;
- (b) Support for identifying gaps in care;
- (c) Ability to identify non-established patients;
- (d) Identify patients who need follow-up communication; **and**
- (e) Clinician attribution for patients in the health care home.

ACCESS AND COMMUNICATIONS

ACCESS TO SERVICES (ATS)

Goal is to ensure all patients have comprehensive and timely access to health care services that are patient centered, culturally sensitive, and delivered in the least intensive and most appropriate setting based on the patient's needs.

Standard ATS-1: Patient Access to Services and Information

The *Practice* has a process to ensure that patients:

- (a) Have access to timely appointments with appropriate clinician(s);
- (b) Have access to referrals with appropriate specialist(s), if applicable;
- (c) Receive clearly specified hours of office operation and location(s);
- (d) Receive instructions about what to do in an emergency; **and**
- (e) How to access after hour services non-emergency and urgent care needs.

Standard ATS-2: Enhancing Patient Access to Services

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

- (a) A process for patient/caregiver to select a personal clinician or team, if applicable;
- (b) Maintains a record of the patient /caregiver's choice of clinician/team in the health record;
- (c) Uses standing orders for routine medication refills, tests, wellness/preventive services;
- (d) Documents clinical advice in the patient health records;
- (e) Provides a copy of health information upon request;
- (f) Provides care plan summaries for patient/caregiver at each office visit; **and**
- (g) Monitors proportion of patient visits that occur with assigned clinician/team.

Standard ATS-3: Ensure Equitable Access and Services

The *Practice* has a policy in place supporting the ethical framework that includes prohibition of discrimination against a patient or group of patients' access to care and services.

COMMUNITY SERVICES & RESOURCES (CSR)

Goal is to help patients connect with needed community services and resources by implementing processes that coordinate care between the PCHCH, community services agencies, family, caregivers, and the patient.

Standard CSR-1: Comprehensive Services and Resources

The *Practice* establishes and:

- (a) Provides information to patients about community services and resources;
- (b) Maintains an updated list of community services and resources; **and**
- (c) Obtains input from patients and PCHCH team members for the community services and resources.

Standard CSR-2: Collaboration with Community Resources

The *Practice* implements mechanisms to promote coordination, collaboration, and communication with appropriate community-based agencies and organizations.

Standard CSR-3: Community Resource Referrals

The *Practice* has a process in place to utilize a referral system for community resources such as services beyond the Practice for patients, which may include community services, mental health, case management and other services.

Standard CSR-4: Tracking and Follow-Up of Community Resource Referrals

The *Practice* has a process in place to:

- (a) Track referrals of high-risk patients to community resources made available by the care team;
- (b) Ensure patients receive appropriate referrals to community resources;
- (c) Ensure patients receive care or services related to the referral; **and**
- (d) Ensure patients comply and benefits from guidance and services received.

TESTING AND REFERRALS

MANAGING TESTS AND RESULTS (MTR)

Goal is to implement a standardized, reliable system to ensure patients receive needed tests and imaging, that results are communicated in a timely manner, appropriate follow-up care is conducted, and each step in the test/imaging tracking process is properly documented.

Standard MTR-1: Documented Process for Ordering Tests

The *Practice* has a documented process in place for ordering tests that includes tracking diagnostic and routine tests ordered.

Standard MTR-2: Documented Process for Managing Test Results

The *Practice* has a documented process in place to manage all tests and imaging ordered that includes:

- (a) Establishing time frame for receiving results;
- (b) Flagging overdue results;
- (c) Flagging abnormal results, as well as duplicate results;
- (d) Establishing time frame for notifying patients of results;
- (e) Following-up with patients regarding abnormal results;
- (f) A mechanism in place for patients to receive information for normal results; **and**
- (g) Ensuring all test results are recorded in the health record.

REFERRAL PROCESS (RP)

Goal is to create a well coordinated process where PCHCH patients are referred to specialty care in an efficient manner, and both the practice clinicians and specialists receive timely access to the information they need to provide optimal care to the patient.

Standard RP-1: Referrals Process

The *Practice* has an established process to:

- (a) Identify patients who need a referral;
- (b) Coordinate referrals;
- (c) Ensure referrals are made to specialists and/or appropriate programs; **and**
- (d) Involve patients in selecting the clinician(s).

Standard RP-2: Referral Information

The *Practice* maintains information on specialists that includes:

- (a) Specialist's contact information;
- (b) Specialist's area of concentration;
- (c) Timeliness of appointments;
- (d) Specialist's mode of communication preference with patients and clinicians; **and**
- (e) Ability to provide information regarding patient's referral visits to the PCHCH.

Standard RP-3: Specialist Appointments

The *Practice* support staff routinely offers assistance to patients to:

- (a) Provide outbound administrative calls **and**
- (b) Schedule specialist appointments on behalf of patients.

Standard RP-4: Electronic-Based Tools for Referrals

The *Practice* uses an electronic tool with specific criteria that:

- (a) Allows integrated collaborative team relationship between specialists and the PCHCH practice care team; **and**
- (b) Prevents duplication of care and/or services.

Standard RP-5: Track and Follow-Up on Referral

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

- (a) Provides the patient and/or caregiver 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 the health record;
- (d) Conducts follow-up to obtain a report from the referral clinician; **and**
- (e) Contacts patient for follow-up if necessary based upon report from specialist.

CARE MANAGEMENT AND COORDINATION**WELLNESS AND HEALTH PROMOTION (WHP)**

Goal is to ensure patients receive all appropriate wellness and preventive services, utilizing screening, active counseling, and outreach efforts to inform and educate patients about the value of preventive care.

Standard WHP-1: Promoting Wellness

The *Practice* is proactive in promoting wellness and preventive care, which includes:

- (a) Use of health assessment tools; **and**
- (b) Information about lifestyle changes and risk factors.

Standard WHP-2: Wellness and Prevention Services

The *Practice* has standing wellness and preventive services order protocols and ensure:

- (a) All patients receive appropriate wellness and preventive care information about:
 - (i) Personal health lifestyle behaviors; **and**
 - (ii) Reducing risk of disease and injury;
- (b) All patients receive appropriate well care visits and preventive screenings; **and**
- (c) Practice care team members are allowed to authorize and deliver preventive services according to clinician-approved protocols without examination by a clinician.

Standard WHP-3: 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.

Standard WHP-4: Wellness Information and Materials

The *Practice* provides information and/or materials about wellness and health promotion to its patients, which:

- (a) Are evidence-based;
- (b) Inform and educate patient/caregiver about how the wellness services works;
- (c) Describe the benefits, the potential outcomes, and the interventions associated with the wellness program;
- (d) Are accessible and available to patients through multiple formats; **and**
- (e) Supports patient advocacy and empowerment.

Standard WHP-5: Documentation of Resources

The *Practice* documents educational resources provided to individual patients.

Standard WHP-6: Secondary Prevention Program

The *Practice* has secondary prevention programs 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.

Standard WHP-7: Collection of Wellness-Related Health Encounter Patient Data

The *Practice* has a process in place to:

- (a) Disclose to the *patient* the purpose(s) and use of all data collected and used during the wellness assessment process; **and**
- (b) Inquire about a patient's outside wellness-related health encounters and has the capability to incorporate information in a patient tracking system registry or health record.

Standard WHP-8: Patient Reminders

The *Practice* sends reminders to appropriate patients:

- (a) For relevant preventive care;
- (b) Who did not schedule appropriate care within a specified timeframe, **and**
- (c) Who were previously contacted by a PCHCH team member.

INDIVIDUAL CARE MANAGEMENT (ICM)

Goal is to ensure patients with chronic conditions receive organized, planned care from a team of multi-disciplinary clinicians, and that patients are empowered to take greater responsibility for their health, leading to improved health status and decreased health care costs.

Standard ICM-1: Care Management – Integrated Team

For patients participating in the PCHCH, the *Practice* identifies the members of the health care team assigned to individual patients and establishes a plan of care that includes the strategy for coordinating care among the health care team members.

Standard ICM-2: Ongoing Care Management Protocols –All Patients

The *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;
- (b) Develops an individualized care plan including treatment goals in collaboration with patients and caregivers that addresses patient's comprehensive care needs;
- (c) Incorporates evidence-based guidelines in the patient's care plan, as available;
- (d) Reviews care plan and assesses progress toward treatment goals at each visit;
- (e) Offers the patient a clinical summary of the visit and if accepted, provides a copy to the patient, at each office visit;
- (f) Assesses and arranges or provides treatment for behavioral health and substance abuse problems;
- (g) Follows up with patients when they have not kept appointments;
- (h) Follows up with patients when they have not followed through on referrals for diagnostic, therapeutic or consultative services; **and**
- (i) Follows up with patients between visits as needed based upon identified clinical condition and health goals.

Standard ICM-3: Informed Decision-Making with Patients

The *Practice* establishes and implements policies and procedures to promote *patient* decision-making which specify:

- (a) The information the *Practice* will make available to support clinical decision-making of *patients*;
- (b) The decision support tools and materials it will make available to *patient*; **and**
- (c) The process for engaging *patients* in decisions regarding the *PCHCH* program.

Standard ICM-4: Chronic Condition – Care Management

The *Practice* provides individualized care management of its patients related to the patients' chronic condition and:

- (a) Identify at least one chronic condition for initial focus; **and**
- (b) Monitors key clinical data, clinical outcome measures, and process measures.

Standard ICM-5: Self-Management

Patients are offered and provided adequate education and guidance to support self-management of their chronic disease through collaborating with their clinician on the self-management goals.

Standard ICM-6: Chronic Condition – Appointments

The *Practice* has the ability to implement an appointment system for all patients that:

- (a) Tracks planned visits;
- (b) Tracks applicable appointments;
- (c) Provides appropriate notification via applicable source of communication; **and**
- (d) Generate reminders, if applicable.

Standard ICM-7: Chronic Condition – Follow-Up

The *Practice* has a process in place to follow-up with all selected chronic condition patients and provides supportive reminders.

Standard ICM-8: Medication Review and Reconciliation

The *Practice* has implemented a documented procedure to:

- (a) Perform medication review at each patient’s visit by a clinician(s);
- (b) Identify types of patient events that are eligible for a medication reconciliation by a clinician at select visits; **and**
- (c) Determine when clinically-equivalent generic substitutions can be recommended giving due consideration to cost and patients’ benefits design.

COORDINATION OF CARE (COC)

Goal is to improve patient care by implementing processes that will help clinicians coordinate treatment, communicate with one another, manage health care setting transitions, communicate care options to the patients, and track patient activity.

Standard COC-1: Coordination of Care

The *Practice* communicates and coordinates care with multi-disciplinary team to ensure:

- (a) Ongoing relationships;
- (b) Notification of treatments;
- (c) Collaborative plan of action for transfers between hospitals, facilities, and other acute or sub acute care setting for patients;
- (d) Emergency room visits; **and**
- (e) Systematic tracking of care coordination activities.

Standard COC-2: Health Record Information Exchange and Alerts

The *Practice* has a process to ensure that appropriate:

- (a) Medical information communicated bidirectional to include clinicians, specialty pharmacies, drug therapy management pharmacies, for all patients with high prevalence/high-risk; **and**
- (b) Alerts of health issues are identified for all patients with high prevalence/high-risk.

Standard COC-3: Written Transition Plans

The *Practice* has a 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 various locations and/or levels of care, starting with the hospital.

Standard COC-4: Coordination of Care with Non-PCHCH Care Management

The *Practice* has a process is in place to coordinate care with employer and /or payer case manager for patients with complex or catastrophic conditions.

Standard COC-5: Coordinating Care Site Transitions

The *Practice* has the following processes in place with local health care facilities to help ensure smooth transitions in care for its patients. The processes address the ability to:

- (a) Identify patients with an unplanned hospital admission or emergency department visit;
- (b) Transmit a patient's clinical information to a hospital or emergency department in a timely fashion;
- (c) Make contact with patients having unplanned hospital admissions or emergency department visits within reasonable time frames after being notified (as defined in PCHCH's policies);
- (d) Establish formal care agreements with hospitalists who provide care to PCHCH patients; **and**
- (e) Ensure hospitalizations and emergency department visits are documented in the patient's health record.

Standard COC-6: Coordination of Care Program for All Chronic Conditions

The *Practice* offers coordination of care for those patients requiring the service.

Standard COC-7: Coordination of Care Program for All

The *Practice* establishes and implements a process to coordinate care that includes procedures for:

- (a) Coordinating referrals for *patients*;
- (b) Managing *patients* with co-morbid clinical *conditions*; **and**
- (c) Communicating with other health care *organizations* when the *patient* is transferred to another program or the benefit is terminated.

Standard COC-8: Appropriate Use of Clinical Guidelines

The *Practice* has policies in place to assign and implement interventions for clinical condition based on clinical or evidence-based guidelines, where:

- (a) Rates of provision (implementation of guidelines) for services are tracked and compared to clinical guidelines;
- (b) *Practice* identifies gaps in care and takes appropriate action; **and**
- (c) *Practice* takes corrective measures, where indicated.

SELF-MANAGEMENT SUPPORT (SMS)

Goal is to implement a comprehensive program that will utilize patient education tools, informative sessions, and life skills training to offer support to chronic care patients, and help them to manage their condition.

Standard SMS-1: Chronic Condition – Self-Management Support and Implementation

The *Practice* chronic condition self-management support includes:

- (a) Shared goal-setting based on types of condition within the *Practice*;
- (b) Implemented based on prevalence of condition; **and**
- (c) Follow-up for all selected chronic condition patients and other patients who are engaged in self-management support to discuss action plans and goals, and provide supportive reminders.

Standard SMS-2: Assessment of Patient Self-Care Capabilities

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

Standard SMS-3: 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.

ADVANCED ELECTRONIC CAPABILITIES

ELECTRONIC PATIENT REGISTRY (EPR)

Goal is to establish a comprehensive patient registry to optimally manage a population of patients, improve health status, and ultimately lower health care costs. Identification of care gaps and needed preventive services and follow-up services should be included in key functionalities.

Standard EPR-1: Electronic Registry

The *Practice* has a fully electronic registry with various features including:

- (a) Search capabilities;
- (b) Flagging capabilities;
- (c) Report generation; **and**
- (d) The ability to update from all *Practice* locations.

Standard EPR-2: Electronic Registry Function

The *Practice* electronic registry has been implemented and includes:

- (a) Patient information;
- (b) Care guidelines;
- (c) Support for flagging gaps in care; **and**
- (d) Ability to identify non-established patients.

ELECTRONIC COMMUNICATIONS PORTAL (ECP)

Goal is to implement a patient portal system that will allow clinicians to manage and interact with their patients online. Patients will be able to access their health records online, and the clinician will be able to send reminders and health care literature, and conduct e-visits.

Standard ECP-1: Electronic Communications Portal – Patient Self-Services

The *Practice’s* electronic communications portal is available to all patients and provides the ability for them to:

- (a) Schedule appointments; **and**
- (b) Input self-administered biometric results and graphs results.

Standard ECP-2: Bidirectional Electronic Communications Portal

If the *Practice* has a bidirectional electronic communication portal, it provides the ability for patients to:

- (a) Create a personal health record;
- (b) View electronic health records; **and**
- (c) View test results, if applicable.

Standard ECP-3: Electronic Communications Portal Interactions

The *Practice* electronic communication portal allows:

- (a) Clinician to receive notification for patient’s self-reported data with indications of potential health risk;
- (b) Clinician to send communication to patients that includes wellness care reminders and patient educational information; **and**
- (c) Patient and clinician to interact via electronic visits (e-visits).

Standard ECP-4: Electronic Communications Portal Review

The *Practice* maintains written policies and documented procedures for implementation and maintenance of its electronic communications portal, which:

- (a) Address confidentiality, privacy and security; **and**
- (b) Are reviewed annually and updated as needed.

Standard ECP-5: Electronic Communications Portal Disclosures

The *Practice* discloses to *users* of its electronic communications portal the type of information that will be collected and how the information will be used.

Standard ECP-6: Electronic Communications Portal – Opt-in or Opt-out

The *Practice* through its patient electronic communications portal:

- (a) Explains to all patients that they have the option to opt-in or opt-out at any point;
- (b) Collects personally-identifiable information only for users who opt-in for collection;
and
- (c) Describes the consequences of providing, and not providing such information.

Standard ECP-7: Evaluation of Electronic Communications Portal

The *Practice's* electronic communications portal may be *Practice*-operated or vendor-based; however, either way the *Practice* must evaluate the portal's features and conduct a risk assessment prior to purchasing and implementing an electronic communications portal.

ELECTRONIC PRESCRIBING AND DISPENSING (EPD)

Goal is to automate the prescribing and medication reconciliation process, providing alerts for medication and allergy conflicts, therapeutic equivalent and generic substitution information, streamlining prescription fills and renewals, and providing clinicians with patient-specific coverage and insurance formulary information.

Standard EPD-1: Electronic Prescribing System

The *Practice* employs an electronic prescribing system, which:

- (a) Increases patient safety;
- (b) Convenience; **and**
- (c) Lowers medication cost.

Standard EPD-2: Electronic Prescribing Utilized

The *Practice* employs an electronic prescribing system that has the following capabilities:

- (a) Integrates with the electronic patient registry and/or health records;
- (b) Connects at least two (2) pharmacies and if possible, 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 when appropriate; **and**
- (f) Provides clinician with patient-specific formulary coverage information if available from the health plan.

Standard EPD-3: Dispensing Medication

If the *Practice* dispenses medications, it must:

- (a) Verify medication orders were prepared correctly; **and**
- (b) Ensures appropriate *patient* educational material included with drugs from appropriate source, such as manufacturer or other source.

Standard EPD-4: Electronic Prescribing Notification

The *Practice's* electronic prescribing system has a prescription fill status.

Standard EPD-5: Electronic Prescription Request

The *Practice* has an electronic communications portal that allows patients to request prescription refills.

Standard EPD-6: Electronic Medication Review and Reconciliation

The *Practice* reviews and reconciles its patients' medication(s) prior to refilling.

ELECTRONIC HEALTH RECORDS (EHR)

Goal is to implement an Electronic Health Record which integrates patient information from all care sources, within and outside the practice.

Standard EHR-1: Electronic Health Record

The *Practice* electronic health record includes information gathered and managed by the appropriate clinicians who are involved in patients' health care.

Standard EHR-2: Electronic Health Record Integration

The *Practice* electronic health record integrates health-related information on a patient, which includes care and services received and is managed by the clinician and/or health care team.

Standard EHR-3: Basic Electronic Health Record Functions

The *Practice* electronic health record includes Patient's:

- (a) Medical history;
- (b) Medication list;
- (c) Problem list;
- (d) Clinical notes; **and**
- (e) Viewable test and results.

Standard EHR-4: Advanced Electronic Health Record Functions

The *Practice* advanced electronic health record integrates systems to:

- (a) Order diagnostic tests;
- (b) Request electronic prescriptions;
- (c) View digital images of ordered radiology tests;
- (d) Flag abnormal test results;
- (e) Remind clinicians of appropriate guidelines and wellness screenings;
- (f) Coordinate care; **and**
- (g) Include all elements in EHR-3: Basic Electronic Health Record Function.

PERFORMANCE REPORTING AND IMPROVEMENT

PERFORMANCE REPORTING (PRT)

Goal is to implement reporting technology that will allow clinicians to generate point of care reports, population-level reports, and trend analyses to identify opportunities for improving care delivered to patients. Regular performance feedback enables clinicians to decrease gaps in care and improve patient outcomes.

Standard PRT-1: Analysis of Performance Reporting Data

The *Practice* on a continuous and per event basis obtains and analyzes data on its patients:

- (a) Emergency Room visits;
- (b) Ambulatory-care sensitive hospitalizations; and
- (c) Disease-specific re-hospitalizations to identify all instances and root causes of unnecessary or avoidable utilization.

Standard PRT-2: Performance Reporting – Tracking and Reporting

The *Practice* has the resources and mechanisms in place to produce and report on a periodic basis on:

- (a) Patients identified as having high prevalence and/or high-risk conditions; **and**
- (b) Non-high prevalence and/or high-risk conditions, if applicable.

Standard PRT-3: Levels of Performance Reporting

The *Practice* performance reports include but not limited to information from the following:

- (a) Individual clinician;
- (b) Individual *Practice* location(s);
- (c) Practice; **and**
- (d) Multi-*Practice* organization.

Standard PRT-4: Performance Reporting Validation

The *Practice* has a process in place to validate its performance data and ensure it accurately reflects the information.

Standard PRT-5: Performance Reporting – Trends Analysis and Action

The *Practice* receives and acts on trend data showing its impact on unnecessary or avoidable utilization and reducing costs as well as cost growth for its patient population as a whole over time.

Standard PRT-6: Performance Reporting

The *Practice's* performance reports address:

- (a) All patients that received primary wellness/preventive services;
- (b) All patients that received secondary wellness/preventive services;
- (c) All patients identified as having a high-risk/high-prevalence chronic condition;

- (d) All patients who agreed to participate in the PCHCH program;
- (e) Services provided by specialists; **and**
- (f) Services provided by diagnostic testing facilities, hospitals, and other health care clinicians or providers.

Standard PRT-7: Performance Reporting Transparency

The *Practice* has written policies and documented procedures for openly sharing its performance data and trends with patients, payers, and governmental agencies for:

- (a) Public reporting and comparative purposes; **and**
- (b) Willingly discusses this performance information with current and prospective patients/caregivers.

Appendix A: *Not Included in the Standards Only Version*

Appendix B: **PCHCH Quality Improvement Reference Resources**

The Performance Measures Information Resource and the Survey Information Resource below provide practices with options for collecting and analyzing information on how well they are performing both clinically and from the patient perspective, with the goal of using the results for quality improvement activities.

These resources are available free of charge by download from the URAC Store at:

<http://www.urac.org/forms/store/CommercePlusFormPublic/search?action=Feature>

- **Performance Measures Information Resource**

The Performance Measures Information Resource offers a collection of publicly available, free of charge, non-proprietary performance measures which practices can use to collect data on care processes and clinical outcomes to facilitate continuous quality improvement, public reporting, and incentive payment programs. The measures in this information resource are intended to help a practice assess its progress in delivering care at the enhanced level of quality and oversight expected of a patient centered health care home. Content of the Performance Measures Information Resource will be regularly reviewed and updated.

- **Survey Information Resource**

The Survey Information Resource will contain one or more validated surveys to provide practices with tools to collect patient, family, and caregiver feedback on their effectiveness in providing the level of patient centered care and customer satisfaction that would be expected from a Patient Centered Health Care Home (PCHCH). Survey results will be useful for quality improvement activities, as well as for public reporting and marketing activities.

Currently, URAC is recommending the use of the Patient-Centered Medical Home (PCMH) version of the CAHPS Clinician & Group Survey, now under development by the Agency for Healthcare Research and Quality, with a projected release date of summer, 2011. To learn more about this survey and its content, go to:

https://www.cahps.ahrq.gov/content/products/CG/PROD_CG_PCMH.asp

URAC will periodically reassess the Survey Information Resource, adding, deleting, or modifying its contents as new survey instruments become available or are validated. Over time, URAC intends to incorporate patient reported outcome measures, provider satisfaction surveys and other survey instruments needed to assess PCHCH activities into the Survey Information Resource.

Appendix C: PCHCH Glossary

In the Patient Centered Health Care Home Program Toolkit, defined terms are *italicized*. The terms are used throughout the Practice Assessment Toolkit. Being familiar with these definitions is critically important to accurate understanding of URAC programs. Readers are encouraged to refer to the definitions section each time they encounter an italicized term until they feel that they have committed the meaning of that term to memory.

TERM	DEFINITION
Access	<p>Access: The <i>consumer's</i> ability to obtain services in a timely manner.</p> <p>Interpretive Note: The measures of <i>access</i> for <i>consumers</i> are determined by components such as the <i>availability</i> of services, their acceptability to the <i>consumer</i>, <i>consumer</i> wait time, and the hours of operation.</p> <p>The measures of <i>access</i> for <i>clients</i> are determined by components such as turn-around time and other metrics as they may be defined in written business agreements, etc.</p>
Adverse Event	A clinical occurrence that is inconsistent with or contrary to the expected outcomes. An adverse event or adverse drug reaction is unexpected in normal therapeutic use and may cause life-threatening conditions.
Assessment:	A process for evaluating individual <i>consumers</i> that have been identified as eligible for a medical management program, such as <i>disease management</i> or <i>case management</i> , to identify specific needs relating to their clinical <i>condition</i> and associated co-morbidities.
Attending Physician	The doctor of medicine or doctor of osteopathic medicine with primary responsibility for the care provided to a <i>patient</i> in a hospital or other health care <i>facility</i> .
Attending Provider	The physician or other health care practitioner with primary responsibility for the care provided to a <i>consumer</i> .
Availability	Meeting the needs of <i>consumers</i> according to the <i>criteria</i> posed to the <i>organization</i> by its <i>clients</i> .
Behavioral Health/Behavioral Health Care	An umbrella term that includes mental health and substance abuse. Services are provided by those who are licensed by the state and whose professional activities address a client's behavioral issues. Licensed mental health practitioners include psychologists, psychiatrists, social workers, psychiatric nurse practitioners, marriage and family counselors, professional clinical counselors, licensed drug/alcohol abuse counselors and mental health professionals. (Behavioral Healthcare: The Practical Resource for the Field's Leaders. http://www.behavioral.net/ME2/Default.asp)
Biometric screening	A biometric screening provides a detailed assessment of a consumer's basic health indicators, which includes, but is not

TERM	DEFINITION
	limited to: <ul style="list-style-type: none"> • Blood pressure • Body mass index (calculated from height and weight) • Cholesterol (total, HDL and LDL) • Blood glucose
Board-Certified	<p>A certification – approved by the <i>American Board of Medical Specialties</i>, the American Osteopathic Association, or another <i>organization</i> as accepted by URAC – that a physician has expertise in a particular specialty or field. To the extent that future URAC standards include other certifications, URAC will specify further approved boards.</p> <p>Note: URAC recognizes that ABMS- and AOA-approved board certifications may not be the only certification programs that may be acceptable for <i>health professionals</i> in URAC-accredited <i>organizations</i>. For example, non-physician professionals will have appropriate certifications that are not ABMS- or AOA-approved. Any applicant wishing to have URAC recognize another board certification program should notify URAC early in the accreditation process. URAC will then take this recommendation to URAC’s Accreditation Committee. The Accreditation Committee will review all requests, and will decide to approve or reject the certification. The Accreditation Committee will consider the following <i>criteria</i> in judging whether a certification is acceptable:</p> <ul style="list-style-type: none"> • Is the certification accepted within its target community of <i>health professionals</i>? • Was the certification developed through an open, collaborative process? • Does the certification reflect accepted standards of practice? • Is the certification administered through an objective process open to all qualified individuals? <p>All approved organizations will be listed in relevant materials provided by URAC. Note also that the term board certification appears only once in the Core Standards, in standard 10, which relates to the clinical qualifications of senior <i>clinical staff</i> people who are physicians.</p>
Caller	<p>The consumer inquiring to obtain health care information. This may also be a representative inquiring on behalf of the consumer.</p>
Care Coordination	<p>The process of aggregating, integrating, sorting, tracking, monitoring and utilizing clinical and psychosocial information on a given individual (a patient) from all the disparate sources that that individual may have received care, or may be scheduled to receive care in the immediate future. Such sources include but are not limited to: primary care sites, specialist sites, ambulatory surgical centers, ambulatory procedure centers (such as GI), ERs Urgent Care, hospitals, long term care facilities, pharmacies, community agencies, etc. The coordination of this information, centered on a given individual is for the purpose of assuring that the best care can be delivered at the right time so as to maximally improve the health, function, and wellbeing of the individual. (It</p>

TERM	DEFINITION
	is recognized that in our present fragmented care delivery system, that care coordination will initially focus in gathering and integrating information related to the most critical elements, such as transitions of care, especially into and from hospital admissions, and emergency departments.) (CMSA.org)
Care Plan	Outlines the care to be provided by the clinician, which includes treatment goals (short and long-term) and addresses patient's comprehensive care needs. The care plan is usually developed in collaboration with the <i>patient/caregiver</i> and may also include personal goals.
Care Team	See health care team.
Case	A specific request for medical or clinical services referred to an <i>organization</i> for a determination regarding the medical necessity and medical appropriateness of a health care service or whether a medical service is experimental/investigational or not.
Case Manager	A collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs using communication and available resources to promote quality cost-effective outcomes.
Caregiver	A caregiver includes family member(s), personal caregiver, significant other, friend who cares for the patient.
Certification	A professional credential, granted by a national <i>organization</i> , signifying that an individual has met the qualifications established by that <i>organization</i> . To qualify under these standards, the <i>certification</i> program must: <ul style="list-style-type: none"> • Establish standards through a recognized, validated program; • Be research-based; and • Be based (at least partially) on passing an examination.
Clinical Decision Support Tools	Protocols, guidelines, or algorithms that assist in the clinical decision-making process.
Clinical Practice Guidelines	Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. (Field MJ, Lohr KN (Eds). Guidelines for clinical practice: from development to use. Institute of Medicine, Washington, D.C: National Academy Press, 1992.)
Clinical Review Criteria	The written screens, decision rules, medical protocols, or drug treatment guidelines used by the <i>organization</i> as an element in the evaluation of medical necessity and appropriateness of services under the auspices of the applicable benefits plan.
Clinical Staff	Employees or contracted consultants of the health care <i>organization or Practice</i> who are clinically qualified to perform clinical triage and provide health education services.
Clinician	See Health Professionals

TERM	DEFINITION
Complaint	<p>An expression of dissatisfaction by a consumer expressed verbally or in writing regarding an organization's products or services that is elevated to a complaint resolution system.</p> <p>Interpretive Note for term "Complaint":</p> <ul style="list-style-type: none"> ○ This term is sometimes referred to as "grievance." ○ This definition does not include appeals.
Comprehensive Wellness Program	<p>A program that is designed to promote <i>healthy behaviors</i> through a combination of a <i>health risk assessment process</i>, a series of one or more <i>interventions</i>, and a <i>program evaluation</i> component designed to track individual and program-wide aggregate improvements, supported by a means of program and data <i>integration</i>.</p>
Condition	<p>A diagnosis, clinical problem or set of indicators such as signs and symptoms a <i>consumer</i> may have that define him/her as eligible and appropriate to participate in a clinical program.</p>
Confidentiality	<p>The protection of individually identifiable information as required by state and federal legal requirements and Partners policies. (HIPAA Glossary)</p>
Conflict of Interest	<p>Any relationship or affiliation on the part of the <i>organization</i> or a <i>reviewer</i> that could compromise the independence or objectivity of the independent review process. <i>Conflict of interest</i> includes, but is not limited to:</p> <ul style="list-style-type: none"> • An ownership interest of greater than 5% between any affected parties; • A material professional or business relationship; • A direct or indirect financial incentive for a particular determination; • Incentives to promote the use of a certain product or service; • A known familial relationship; • Any prior involvement in the specific <i>case</i> under review.
Consultant	<p>A professional who provides advice in specific areas of expertise (e.g., health care, pharmacy, case management, utilization management, etc.) and usually has a wide knowledge of the subject matter. The consultant usually has a defined scope of work through documents such as, but not limited to, contracts, master service agreements, scope of work, etc. These individuals are not considered staff (i.e., employees) of the organization. [See staff]</p>
Consumer	<p>An individual person who is the direct or indirect recipient of the services of the organization. Depending on the context, consumers may be identified by different names, such as "member," enrollee," "beneficiary," "patient," "injured worker," "claimant," etc.</p> <p>A consumer relationship may exist even in cases where there is not a direct relationship between the consumer and the Organization. For example, if an individual is a member of a health plan that relies on the services of a utilization management organization, then the individual is a consumer of the utilization management organization.</p>

TERM	DEFINITION
	<p>Interpretive Note for term “Consumer”: In the case of a consumer who is unable to participate in the decision-making process, a family member or other individual legally authorized to make health care decisions on the consumer behalf may be a consumer for the purposes of these standards.</p>
Consumer Safety	The prevention of harm to <i>consumers</i> .
Continuity of Care	Continuity of care is the process by which the patient and the physician are cooperatively involved in ongoing health care management toward the goal of high quality, cost-effective medical care. (American Academy of Family Practice, www.aafp.org)
Criteria	<p>Criteria: A broadly applicable set of standards, guidelines, or protocols used by the <i>organization</i> to guide the clinical processes. Criteria should be:</p> <ul style="list-style-type: none"> • Written; • Based on professional practice; • Literature-based; • Applied consistently; and • Reviewed, at a minimum annually. <p>All approved organizations will be listed in relevant materials provided by URAC. Note also that the term <i>board certification</i> appears only once in the Core Standards “Senior Clinical Staff Requirement,” which relates to the clinical qualifications of senior clinical <i>staff</i> people who are physicians.</p>
Cultural Appropriateness	Also referred to as cultural competence, describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs. (“Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches,” Commonwealth Fund, October 2002.)
Culture, PCHCH	The underlying ethos, beliefs, way of relating/respecting other, which includes respect for everyone’s role and collaboration and contributions to the overall care of the patient.
Disease Management (DM)	According to the Disease Management Association of America, “Disease management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management: supports the physician or practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health. Disease management components include: population identification processes; evidence-based practice guidelines; collaborative practice models to include physician and support-service providers; patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance);

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	process and outcomes measurement, evaluation, and management; routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling.”
Disease Registry	A Disease Registry is a large collection or registry belonging to a health care system that contains information on different chronic health problems affecting patients within the system. A Disease Registry helps to manage and log data on chronic illnesses and diseases. All data contained within the Disease Registry are logged by health care providers and are available to providers to perform benchmarking measures on health care systems. (Robert Wood Johnson Foundation)
Drug/Medication Management	Evaluation of patients’ drug/medication profiles related to covered benefits, clinical appropriateness and safety for patients’ use of medications.
Drug Therapy Management (DTM)	A distinct service or group of services that optimize therapeutic <i>outcomes</i> for individual <i>consumers</i> as a result of appropriate drug therapy. (Adapted from Academy of Managed Care Pharmacy’s (AMCP) Principles of a Sound Drug Formulary System, 2000.)
Electronic	Mode of electronic transmission including the Internet (wide-open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media. (Final Rule, Department of Health and Human Services, “Health Insurance Reform: Standards for Electronic Transactions,” <u>Federal Register</u> (Aug. 17, 2000).
Electronic Health Record	An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.
Electronic Medical Record	An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.
Electronic Prescribing (e-prescribing)	<p>Prescription information that is created, stored and transmitted via electronic means, (e.g., by computer or hand held device). The process is more than the capability to transmit new prescriptions from prescribers to a pharmacy. Among other things it includes allowing pharmacies to transmit refill requests to the prescriber and prescribers to respond with their authorization, denial, or changes. The term electronic prescriptions would not apply to prescriptions communicated either by facsimile ("Fax") or verbally in a telephone conversation. Electronic transmission offers benefits over written and oral prescription transmission in terms of accuracy, storage capacity, accessibility, security, productivity and minimizing the potential for adverse drug events. Additional benefits of electronic prescriptions are:</p> <ul style="list-style-type: none"> • Reduction of errors due to: <ul style="list-style-type: none"> ○ Illegible handwriting; ○ Confusing similarly-sounding drug names with oral

TERM	DEFINITION
	<p>prescription orders and</p> <ul style="list-style-type: none"> ○ Order-entry errors ● Provide prescribers with information about: <ul style="list-style-type: none"> ○ Appropriateness of their prescriptions ○ Other drugs the patient is taking prescribed by the same or other doctors which may result in: <ul style="list-style-type: none"> - Serious drug interactions - Dangers with drug allergies - Duplicate drugs or overlapping drug classes ○ Other diseases and medical/health record information, including: <ul style="list-style-type: none"> - Diseases where certain drugs can cause harm - Correct dosing (age, weight, gender) ○ Drug coverage by health plan such as: <ul style="list-style-type: none"> - Formulary status - Preferred drugs - Step therapy <p><i>Adapted from 2002 Academy of Managed Care Pharmacy (AMCP) Policy Statement</i></p>
<p>Electronic Prescribing Network (e-prescribing Network)</p>	<p>A secure electronic network that allows pharmacy systems and payer/PBM systems to connect in real-time to provide patient eligibility, medication history and formulary and benefit information to prescribers at the point of care, and then route the prescription to the pharmacy of the patient’s choice, either retail or mail service.</p>
<p>Employee</p>	<p>One who is hired by an employer to do a specific job and contributes labor and expertise to an organization. This person can be a full-time or part-time employee.</p> <p>Note: When using temporary personnel (i.e., through a Professional Employment Organization known as “POE”) or other contracted positions to perform the same or similar labor as staff, it is URAC’s intent that the requisite confidentiality and conflict of interest training as well as function-specific orientation and training are covered.</p> <p>By way of example, temporary nursing personnel stepping into regular employee roles to supplement existing staff would need to receive the requisite orientation and training, enough to perform in their assigned role. The same applies to contracted physicians conducting peer clinical review and/or appeals as part of the utilization management (UM) function.</p> <p>In contrast, “consultants” do not perform the functions of the program – at least not to the extent temporary personnel would. Instead they provide their expertise in their role as consultants and often have an assignment associated with a particular project. Refer to the definition of “consultant” for further information.</p>
<p>Error</p>	<p>The failure of a planned action to be completed as intended (i.e., <i>error</i> of execution) or the use of a wrong plan to achieve an aim (i.e., <i>error</i> of planning).</p>

TERM	DEFINITION
Evidence-Based	Recommendations based on <i>valid</i> scientific <i>outcomes</i> research, preferably research that has been published in peer reviewed scientific journals. <i>Evidence-based</i> information can be used to develop protocols, pathways, standards of care or clinical practice guidelines and related educational materials.
Evidence Based Medicine	"Evidence based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients." David L. Sackett, William M. C. Rosenberg, J.A. Muir Gray, R. Brian Haynes, W. Scott Richardson. Evidence based medicine: what it is and what it isn't. British Medical Journal 1996; 312:71-72. Reproduced with permission from BMJ Publishing Group.
Family	Individuals whom the consumer chooses to involve in the decision-making process regarding the consumer's health care. In the case of a consumer who is unable to participate in the decision-making process, "family" shall include any individual legally authorized to make health care decisions on the consumer's behalf.
Formulary	A continually updated list of medications (could include transaction lists and preferred lists) and related information, representing the clinical judgment of physicians, pharmacists, and other experts in the diagnosis and/or treatment of disease and promotion of health. (Adapted from Academy of Managed Care Pharmacy's (AMCP) Principles of a Sound Drug Formulary System, 2000.)
Generic Substitution	<p>The substitution of generic drug products that contain the same active ingredient(s) and are chemically identical in strength, concentration, dosage form, and route of administration to the brand drug product prescribed. <i>Health professionals</i> and <i>consumers</i> can be assured that FDA approved generic drugs have met the same rigid standards as the innovator drug. To gain FDA approval, a generic drug must:</p> <ul style="list-style-type: none"> • Contain the same active ingredients as the innovator drug (inactive ingredients may vary); • Be identical in strength, dosage form, and route of administration; • Have the same use indications; • Be bioequivalent; • Meet the same batch requirements for identity, strength, purity, and quality; and • Be manufactured under the same strict standards of FDA's good manufacturing practice regulations required for innovator products <p>(Adapted from Academy of Managed Care Pharmacy's (AMCP) Principles of a Sound Drug Formulary System, 2000.)</p>
Health Care Team	<p>The attending physician and other health care providers/clinicians with primary responsibility for the care provided to a consumer/patient.</p> <p>Note: The health care team may include but is not limited to physicians, pharmacists, nurses, behavioral health, social</p>

TERM	DEFINITION
	workers, specialists, therapists, and medical assistant including other paraprofessionals and non-clinicians of the health care system.
Health Content Reviewer	An individual who holds a license or certificate as required by the appropriate jurisdiction in a health care field (where applicable), has professional experience in providing relevant direct patient care or has completed formal training in a health-related field.
Health Education	Educational resources designed to enhance the knowledge and understanding of health topics to promote wellness and self-care.
Health Information	Educational resources designed to enhance the knowledge and understanding of health topics to promote wellness and self-care.
Health Information Organization	The electronic movement of health-related information among organizations according to nationally recognized standards.
Health Literacy	The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate decisions regarding their health.
Health Professional	<p>An individual who: An individual who: (1) has undergone formal training in a health care field; (2) holds an associate or higher degree in a health care field, or holds a state license or state certificate in a health care field; and (3) has professional experience in providing direct patient care.</p> <p>The term “health professionals” may include but is not limited to physicians, pharmacists, nurses, behavioral health social workers, nurse practitioners, physician assistants, dietitians, physical therapists, speech therapists, and occupational therapists.</p>
Health Risk Assessment Process	<p>A process of collecting and interpreting health data and risk factors, gathered from the <i>health risk assessment tool</i> and other sources about the <i>target population</i>, to evaluate potential <i>participants</i> for inclusion in the <i>wellness program</i>.</p> <p>Note: The term “health risk assessment” and its corresponding acronym “HRA” are not the only terms that define an acceptable assessment process.</p>
Health Risk Assessment Tool (HRAT)	<p>A <i>health risk assessment tool</i> is a systematic approach to collecting information from individuals that identifies <i>risk factors</i>, which can be determined through biometric and other methods, and provides individualized feedback, such as through a health risk score, to increase overall awareness of risk. Definition adopted from the Centers for Medicare and Medicaid Services – CMS)¹</p>
Individual Care Plan	<p>A nursing care plan outlines the nursing care to be provided to a patient. It is a set of actions the nurse will implement to resolve nursing problems identified by assessment. The creation of the plan is an intermediate stage of the nursing process. It guides in the ongoing provision of nursing care and assists in the evaluation of that care.</p>

¹[1] http://www.cdc.gov/nccdphp/dnpa/hwi/program_design/health_risk_appraisals.htm

TERM	DEFINITION
Individually Identifiable Health Information	URAC uses the Health Insurance Portability and Accountability Act (HIPAA) definition of this term.
Individually Identifiable Information	Any information that can be tied to an individual consumer, as defined by applicable laws.
Job Description	A job description is a useful, plain language tool that describes the tasks, duties, functions, and responsibilities of a position. It outlines the details of who performs the specific type of work, how that work is to be completed, and the frequency and the purpose of the work as it relates to the company's mission and goals. (Society for Human Resources Management website: www.shrm.org)
License	A <i>license</i> or permit (or equivalent) to practice medicine or a health profession that is (1) issued by a state regulatory body or jurisdiction in the United States U.S.; and (2) required for the performance of job functions. Interpretive Note for term "License": In this definition, the word "equivalent" includes certifications, registrations, permits, etc. Specific terms will vary by state and health profession.
Meaningful Use	URAC uses the definition for the term promulgated by the Office of the National Coordinator for Health Information Technology – "electronic health records and meaningful use" – http://healthit.hhs.gov
Medication Error	Any preventable or avoidable event that may cause or lead to inappropriate medication use or may cause harm to patient. Medication errors may occur by the patient or while the patient is in the control of the health care professional or caregiver.
Medication Reconciliation	The process of creating the most accurate list possible of all medications a patient is taking - including drug name, dosage, frequency, and route - and comparing that list against the physician's admission, transfer and/or discharge orders, with the goal of providing correct medications to the patient at all transition points. Note for term "Medication Reconciliation": This definition comes from the Institute for Healthcare Improvement (IHI), <i>Reconcile Medication at All Transition Points</i> , available through the following Web site: www.ihl.org .
Medication Therapy Management	See Drug Therapy Management.
Medication Management	See Drug/Medication Management.

TERM	DEFINITION
Opt-In	<p>Affirmative consent actively provided by a <i>consumer</i> to participate in an activity or function of the <i>patient centered health care home program (PCHCH)</i>, provided after the <i>PCHCH program</i> has fully disclosed the terms and conditions of participation to the <i>consumer</i>.</p> <p>Note: Auto enrollees are not considered “opt-in” enrollees of the program.</p>
Opt-Out	<p>A process by which an enrolled <i>consumer</i> declines to participate in an activity or function of the <i>patient centered health care home program</i></p>
Organization	<p>A business entity that seeks accreditation under these standards.</p> <p>Interpretive Note for term “Organization”: This can include a program or department and can be geographically defined. Examples of physician groups covered by this definition include the independent practice association (IPA), physician organization (PO), physician hospital organization (PHO), as well as independent groups of physicians.</p>
Outcome	<p>An <i>outcome</i> is a measure that indicates the result of the performance (or nonperformance) of a program, service, or intervention. The evaluation measures may include: clinical, financial, utilization, economic, quality, and humanistic <i>outcomes</i> (e.g. <i>patient</i> and <i>provider</i> satisfaction).</p>
Participant (participating)	<p>An eligible <i>consumer</i> that has not <i>opted out</i> of the program that has had one or more inbound or outbound contacts with the <i>drug therapy management program</i>.</p>
Participating Provider	<p>A <i>provider</i> that has entered into an agreement with the <i>organization</i> to be part of a <i>provider network</i>.</p>
Patient	<p>A person receiving medical or health care services and/or treatment from a health care provider or practitioner.</p> <p>The enrollee or covered consumer for whom a request for certification may or may not have been filed.</p> <p>Interpretive Note for term “Patient”: In the case of a patient who is unable to participate in the decision-making process, a family member or other individual legally authorized to make health care decisions on the patient’s behalf may be a patient for the purposes of these standards.</p>
Patient Care	<p>The prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health.</p>
Patient Centered Care	<p><i>Patient-centered</i>: providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions. (IOM 2001, Crossing the Quality Chasm)</p> <p>“Patient and family-centered care” means planning, delivering, and evaluating health care through patient-driven, shared decision-making that is based on participation, cooperation, trust, and respect of participant perspectives and choices. It also incorporates the participant’s knowledge, values, beliefs and</p>

TERM	DEFINITION
	cultural background into care planning and delivery. Patient and family-centered care applies to patients of all ages. (MN HCH Rule)
Patient-Centered Health Care Home (PCHCH)	<p>A <i>Patient Centered Health Care Home</i> (PCHCH) is a quality driven, interdisciplinary clinician led team approach to delivering and coordinating care that puts patients, and family members, and personal caregivers at the center of all decisions concerning the patient’s health and wellness. A PCHCH provides comprehensive and individualized access to physical health, behavioral health, and supportive community and social services, ensuring patients receive the right care in the right setting at the right time. In addition, a PCHCH:</p> <ul style="list-style-type: none"> • Empowers patients to be active participants in their care, through patient-friendly education and informed shared decision-making that is based on cooperation, trust, and respect for each individual’s health care knowledge and health literacy, values, beliefs, and cultural background; • Utilizes team based care delivery, with the team sharing responsibility for promoting the overall health, function, and well being of the patient; • Is accountable for coordinating, providing, and monitoring a patient’s needs, including prevention, wellness, medical and behavioral health treatment, care transitions, and social and community services where through the creation of an appropriate individual plan of care; • Utilizes population-based tools to support and monitor wellness and care goals for each patient, aimed at preventing illness and improving individual well being, clinical outcomes and quality of life; • Optimizes value for patients, payers, and society at large, driven by a commitment to care excellence and customer service; and • Provides a rewarding place to work, offering a high level of job training and satisfaction for all members of the team allowing team members to optimize their training and experience.
Patient Engagement	<p>Setting in place practices and services that will enable patients to positively participate in their health and health care to the extent they are able so that the patient/family/caregiver engage in actions individuals must take to obtain the greatest benefit from the health care services available to them. Engagement signifies that a person is involved in a process through which (s)he harmonizes robust information and professional advice with his own needs, preferences and abilities in order to prevent, manage and cure disease.</p>
Patient Management	<p>A collaborative process that assesses, plans, implements, coordinates, monitors, and/or evaluates options and/or services to meet a <i>patient’s</i> health needs through communication and available resources to promote quality, cost-effective <i>outcomes</i>. <i>Patient management</i> may include the <i>patient</i> and/or the care giver, agent or representative authorized to act on the <i>patient’s</i> behalf.</p>

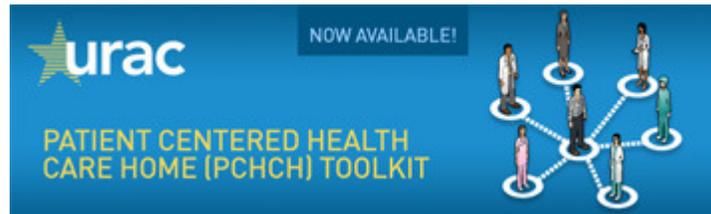
TERM	DEFINITION
Payer	Provides payment for health care services and items. <i>Payers</i> may include the health plan, insurer, the employer, or a pharmacy benefit management company acting on behalf of the health plan or employer.
Performance Measures	Qualitative or quantitative quality indicators for assessing the achievement of outcomes.
Personal Health Information	<p>Any <i>personally-identifiable information</i>, whether oral or recorded in any form or medium, that:</p> <ul style="list-style-type: none"> • Is created or received by a user, owner, health care <i>provider</i>, health plan, public health authority, employer, insurer, school or university, or health care clearinghouse; and • Relates to the past, present, or future physical or mental health or <i>condition</i> of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.
Personally-identifiable Information	Any information that can be tied to an individual identifier.
Pharmacist	A licensed health professional who practices the art and science of pharmacy.
Physician	A licensed health professional, medical practitioner or medical doctor who practices medicine, such as M.D. or D.O.
Physician Assistant	Physician Assistants are health professionals who practice medicine as members of a team with their supervising physicians. PAs deliver a broad range of medical and surgical services to diverse populations in rural and urban settings. As part of their comprehensive responsibilities, PAs conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, and prescribe medications. (www.AAPA.org)
Pilot or Demonstration Program	A health care program which tests new models of health care organization, delivery, and payment.
Plain Language	Communication that uses short words and sentences, common terms instead of (medical) jargon, and focuses on the essential information recipients need to understand.
Practice	<p>The site or location where health care or service is provided. A business entity that seeks recognition, designation and/or accreditation under these standards/toolkits).</p> <p>Interpretive Note for term "Practice": A Practice can include physician groups covered by this definition including the independent practice association (IPA), physician organization (PO), physician hospital organization (PHO), as well as independent groups of physicians and can be geographically located.</p>
Practitioner	An individual person who is <i>licensed</i> to deliver health care services without supervision.
Prescriber	A <i>licensed</i> health care professional that writes <i>prescriptions</i> for <i>consumers</i> within their scope of practice.

TERM	DEFINITION
Prescription	Medication prescribed to a <i>patient</i> or obtained for treatment and prevention of disease or <i>conditions</i> . This may include OTC drugs and related supplies. (From the Academy of Managed 2000.)
Prevention	<p><u>Primary prevention</u> measures fall into two categories. The first category includes actions to protect against disease and disability, such as getting immunizations, ensuring the supply of safe drinking water, applying dental sealants to prevent tooth decay, and guarding against accidents.</p> <p><u>Secondary prevention</u> identifies and detects disease in its earliest stages, before noticeable symptoms develop, when it is most likely to be treated successfully.</p> <p><u>Tertiary prevention</u> programs aim to improve the quality of life for people with various diseases by limiting complications and disabilities, reducing the severity and progression of disease, and providing rehabilitation (therapy to restore functionality and self-sufficiency).</p> <p>Reference: Centers for Disease Control and Prevention – www.cdc.gov</p>
Preventive Care	“Preventive care” means disease prevention and health maintenance. It includes screening, early identification, counseling, treatment, and education to prevent health problems. (MN HCH Rule)
Primary Physician	The physician who is primarily responsible for the medical treatment and services of a consumer.
Privacy	Protects the privacy of individually identifiable health information. Refer to HIPAA Security Rule for additional information.
Professional Competency	The ability to perform assigned professional responsibilities.
Protected Health Information	<p>Individually identifiable health information: (1) Except as provided in paragraph (2) of this definition, that is: (i) Transmitted by electronic media; (ii) Maintained in any medium described in the definition of electronic media at Sec. 162.103 of this subchapter; or (iii) Transmitted or maintained in any other form or medium.</p> <p>(2) Protected health information excludes individually identifiable health information in: (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity in its role as employer. (67 Fed. Reg. at 53,267 (Aug. 14, 2002); 65 Fed. Reg. at 82,805 (Dec. 28, 2000) (to be codified at 45 C.F.R. pt. 164.501)).</p>
Provider	<p>Any person or entity that provides health care services. Includes both <i>practitioners</i> and <i>facilities</i>.</p> <p>A licensed health care facility, program, agency, or health professional that delivers health care services.</p>
Provider Network	A group of providers with which the organization contracts to provide health services to consumers.

TERM	DEFINITION
Quality Management Program	A systematic data-driven effort to measure and improve consumer and client services and/or health care services including consumer safety.
Quality of Care	The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. (Institute of Medicine)
Referral	A direct communication between the Practice/organization and another entity (e.g., a health care provider, specialist) that a patient/consumer will be seeking (or should seek) care or services for a specific health-related issue.
Referring Entity	The organization or individual that refers a case to an organization. Referring entities may include insurance regulators, health benefits plans, consumers, and attending providers. Some states may limit by law which individuals or organizations may be a referring entity.
Registry	<p>A patient registry is an organized system that uses observational study methods to collect uniform (clinical and other) data from and evaluate specified outcomes for a defined population, who have a particular disease, condition, or exposure, to serve predetermined scientific, clinical, or policy purpose(s). Source: "Registries for Evaluating Patient Outcomes," AHRQ Publication No. 07-EHC001.</p> <p>A 'defined population' includes selecting individuals based upon a specific disease entity such as diabetes or, a group of disease entities such as heart disease.</p>
Specialist	A health care provider or other person with specialized health training not available within the health care home. This includes traditional medical specialties and subspecialties. It also means individuals with special training such as chiropractic, mental health, nutrition, pharmacy, social work, health education, or other community-based services. (MN HCH Rule)
Specialty Drugs	<i>Specialty drugs</i> or pharmaceuticals usually require special handling, administration, unique inventory management, a high level of patient monitoring and more intense support than conventional therapies. They could include all routes of administration.
Specialty Pharmacy	<p><i>Specialty pharmacy</i> offers a high touch, comprehensive care system of pharmacological care wherein patients with chronic illnesses and complex disease states receive expert therapy management and support tailored to their individual needs. Medications that health plans and other <i>payers</i> classify as specialty pharmaceuticals may vary and evolve over time.</p> <p><i>Specialty pharmacy</i> incorporates synergistic core elements including:</p> <ul style="list-style-type: none"> • Delivery Channel: Designed to efficiently support the delivery of specialty medications direct to <i>patient</i> or physician; • Business Model: Structured to support expert prescription fulfillment coupled with integrated services within a framework

TERM	DEFINITION
	<p>of rigid quality standards;</p> <ul style="list-style-type: none"> • Service Model: Crafted to achieve measurable improvements in clinical and financial <i>outcomes</i> through tailored patient-centric processes and activities; and • Patient Satisfaction: By meeting/exceeding the clinical and administrative needs of high acuity patients in an environment of continuous quality improvement. <p>The <i>specialty pharmacy</i> is a <i>provider</i> of care and an agent of the <i>patient</i>. The <i>specialty pharmacy</i> is not the <i>payer</i> nor do they define the <i>benefit</i>. The <i>payer</i> may include a third party <i>payer</i> or a <i>patient</i>.</p>
Staff	Means the same as employee. See the definition of “ <i>employee</i> .”
Treating Provider	<p>The individual or <i>provider</i> group who is primarily managing the treatment for a <i>consumer participant</i> in the <i>drug therapy management program</i>.</p> <p>Note: The <i>treating provider</i> is not necessarily the <i>consumers’ primary physician</i>. The <i>consumer</i> may have a different <i>treating provider</i> for different <i>conditions</i>.</p>
Transparency	Health care transparency provides consumers with the information necessary, and the incentive, to choose health care providers based on value. (U.S. Department of Health and Human Services--(http://archive.hhs.gov/valuedriven/))
Wellness	See “Comprehensive Wellness” and “Wellness Program.”
Wellness Organization	The entity that contracts with purchasers to provide wellness programs.
Wellness Program	A program that is designed to promote healthy behaviors through a combination of a health risk assessment tool, a series of one or more interventions linked to the assessment process findings, a program evaluation component designed to track individual and program-wide aggregate improvements, supported by a means of program and data integration.

URAC's Patient Centered Health Care Home Program Toolkit



URAC has developed its Patient Centered Health Care Home (PCHCH) Program Toolkit to educate and guide health care practices, and/or their sponsoring health plans, insurers, and pilot programs, on how to transform practices into truly patient centered health care homes.

What is a Patient Centered Health Care Home?

A **Patient Centered Health Care Home (PCHCH)** is a quality driven, interdisciplinary clinician-led team approach to delivering and coordinating care that puts patients, family members, and personal caregivers at the center of all decisions concerning the patient's health and wellness. A PCHCH provides comprehensive and individualized access to physical health, behavioral health, and supportive community and social services, ensuring patients receive the right care in the right setting at the right time. A PCHCH also:

- Utilizes population-based tools to support and monitor wellness and care goals for each patient, aimed at preventing illness and improving individual well being, clinical outcomes and quality of life;
- Empowers patients and their families/caregivers to be active participants in their care, through patient-friendly education and informed shared decision-making that is based on cooperation, trust, and respect for each individual's health care knowledge and health literacy, values, beliefs, and cultural background;
- Is accountable for coordinating, providing, and monitoring a patient's needs, including prevention, wellness, medical and behavioral health treatment, care transitions, and social and community services where through the creation of an appropriate individual plan of care;
- Optimizes value for patients, payers, and society at large, driven by a commitment to care excellence and customer service;
- Utilizes team based care delivery, with the team sharing responsibility for promoting the overall health, function, and well being of the patient; and,
- Provides a rewarding place to work, offering a high level of job training and satisfaction for all members of the team allowing team members to optimize their training and experience.

Based on the latest research, it is clear a patient centered approach to primary care benefits all. By taking a proactive approach to keeping all patients as healthy as they can be, data shows a significant impact on reducing unnecessary emergency department visits, avoidable hospitalizations and re-hospitalizations – translating to lowered morbidity, mortality, lost days of productivity, and cost savings for our health care system at large.

URAC's PCHCH Program Toolkit Summary

URAC's PCHCH Program Toolkit includes:

- **Practice Assessment Standards, Interpretive Guidance and Checklist** – Enabling practices to self-assess themselves in the following key areas:
 - Core Quality Care Management
 - Patient-Centered Operations Management
 - Access and Communications
 - Testing and Referrals
 - Care Management and Coordination
 - Advanced Electronic Capabilities
 - Performance Reporting and Improvement
- **Performance Measures Information Resource** – Identifying measures directly pertinent to the provision of high quality patient centered care.
- **Survey Information Resource** – Providing an overview and recommendation of publicly available patient experience surveys.

URAC's PCHCH Program Toolkit is the first national program to identify and address the key essential standards needed to become a truly patient centered health care home, including:

1. Greatly enhanced patient access to their health care team;
2. A personal relationship between patients, families, and caregivers and their assigned and accountable health care team members;
3. Shared decision-making that actively engages the patient and respects his/her personal health goals and cultural needs;
4. Direct and ongoing health care team oversight and coordination of all patient care, as well as referral to supportive social and community resources;
5. Smooth and timely health care transitions and follow-up; and
6. Active provisions of the highest quality care possible, elimination of health care disparities, and reduction of care costs by minimization of duplication, reduction of medical errors and unnecessary utilization, and guiding patients to clinically appropriate high value health care.

What the PCHCH Program Toolkit Is and Is Not

URAC's PCHCH Program Toolkit Is	URAC's PCHCH Program Toolkit Is Not
<ul style="list-style-type: none"> • Educational, providing real time, self-paced steps for building PCHCH competencies • Based on a continuous quality improvement approach – the hallmark of all URAC programs – where benchmarking and education are critical components • Flexible and scalable • Results driven, giving full credit for what providers do well, focusing on results rather than the “How” • An easy to follow, step-wise, organized framework to allow self-assessment and tracking of progress • For Medical Home Pilots and Health Plans to use in partnership with physicians and other health care providers 	<ul style="list-style-type: none"> • An accreditation program • A one size fits all model • Rigid with mandatory requirements • A point-in-time audit • Limited to physicians • Technology-centric

How URAC's PCHCH Program Toolkit Can Help Practices Transform Themselves into a PCHCH

By using URAC's PCHCH Program Toolkit and related Informational Resources, practices and their sponsoring organizations can more fully understand what constitutes a fully functional PCHCH, and implement any changes in practice culture, infrastructure, and operations needed to become a PCHCH. URAC's PCHCH Program Toolkit provides a set of measurable steps practices can take in building their PCHCH capabilities and skills, using an educational, self-paced approach – while promoting optimal continuity and quality of care for the patient.

To obtain a complimentary copy of URAC's PCHCH Program Toolkit, please contact:

Mark Gorden, PCHCH Product Manager at: mgorden@urac.org or call (202) 326-3970