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Preventive Services Initiative: Capabilities/Tasks	
9.1	Primary care prevention health promotion program is in place that focuses on modifying personal health behaviors to reduce the risk of disease and injury a. Approach utilizes questions during physical intake that address health promotion issues such as: - Alcohol and Drug Avoidance - Reducing Ultraviolet Light Exposure - Body Mass Index (BMI) - Safe Sex - Breast Self-Examination - Testicular Self-Examination - Lead Screening - Tobacco Avoidance - Low Fat Diet
9.2	Systematic approach is in place to providing preventive services a. Preventive care guidelines are integrated into clinical practice (i.e. Michigan Quality Improvement Consortium) - Adult Preventive Services Guideline 18-49 Yrs - Adult Preventive Services Guideline 50-65 Yrs - Childhood Overweight Prevention Guideline - Prevention of Unintended Pregnancy in Adults - Preventive Service for Children & Adolescents Ages Birth – 24 Mths - Preventive Service for Children and Adolescents Ages 2-18 Yrs - Tobacco Control Guideline b. Systematic appointment tracking & reminder system (implemented as part of Individual Care Management Initiative) incorporates the following elements: 1. Age appropriate health reminders (i.e. annual physicals) 2. Age appropriate immunizations - Pediatric vaccination; person aged 0-6 years - Adolescent vaccination; person aged 7-18 years - Influenza and pneumonia vaccinations person aged 50+ c. Where applicable, patient awareness of Blue Cross Blue Shield of Michigan's online health resources is promoted, for services such as: - HRA/ Wellness Coaching - Blue Health Connection
9.3	Strategies are in place to promote ongoing annual well care visits for children and adolescents 2-21 years of age a. Outreach is conducted to retain children (6-11 years) and adolescents (16-21 years of age)
9.4	Patients are systematically educated about the importance of integrating outside health encounter information into the patient's medical record (e.g., services such as immunizations provided at an immunization fair or a grocery/drug store or mammograms and pap smears that could be ordered by a non-PCP and provided outside of the medical home, etc). Practice unit should include actual/est. date of service.

9.5	Systematic approach ensures documentation of tobacco/smoking cessation assessment tools that include NCQA CAHPS survey questions related to tobacco use - Advising Smokers to Quit - Discussing Smoking Cessation Medications - Discussing Smoking Cessation
9.6	Standing order protocols are in place to authorize nurses (or pharmacists, if appropriate) to administer vaccinations, pap smears, fecal occult blood test and mammogram orders according to physician-approved protocol without examination by a clinician
9.7	Secondary prevention program is in place to identify and treat asymptomatic persons who have already developed risk factors or pre-clinical disease, but in whom the disease itself has not become clinically apparent. Mechanisms are established to identify and intervene with asymptomatic at-risk patients, to lead to a significant improvement in health (e.g., women 40–69 years of age should receive a mammogram to screen for breast cancer at least once every two years). a. System with guideline-based reminders for age-appropriate risk assessment and screening test is in place. PO may choose to implement tools such as checklists attached to the patient chart, tagged notes, computer generated encounter forms, prompting stickers, etc. b. Screening tool is implemented to identify conditions such as: - Postpartum depression - Alcoholism - Depression
9.8	Staff receive regular, formal training in health promotion and disease prevention and incorporate preventive-focused practices into ongoing administrative operations a. Practice unit staff have received minimum basic training in preventive services and health promotion b. Staff person is assigned to update clinical personnel on standards and guidelines such as AHRQ newsletter updates, immunization schedule issued by American Academy of Pediatrics or Centers of Disease Control and Prevention, vaccines standards by Alliance of Immunization in Michigan c. Information is provided to practice units educating them on appropriate billing and ICD-9 codes in order to ensure adequate reimbursement for preventive medicine services - Use of the correct ICD-9 code in order to received proper credit for a physical d. Provide information to practice units regarding consistently using and entering information into the Michigan Care Improvement Registry (MCIR) - Physicians are required by law to report childhood immunization to MCIR within 72 hours of administration - Physicians are requested to report adult immunizations to MCIR (not required by law, but encouraged)
9.9	In order to be successful in achieving full preventive service capabilities, practice units will enhance patient registries implemented under the PCMH patient registry initiative with preventive services

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Linkage to Community Services Initiative: Capabilities/Tasks	
10.1	PO has conducted comprehensive review of community resources for the geographic population that they serve, in conjunction with Practice Units
10.2	POs maintain a community resource database based on input from Practice Units that serves as a central repository of information for all Practice Units. The database may include resources such as the United Way's 2-1-1 hotline, or links to online resources such as the Michigan Primary Care Initiative. • At least one staff person in PO is responsible for conducting a semiannual update of the database and verifying local resource listings (PO may coordinate with Practice Unit staff to ensure resource reliability). It is acceptable for staff to not verify aggregate listings (such as 2-1-1) if they are able to document how often the listings are updated by the resource administrator. • Resource databases are shared with other POs, particularly in overlapping geographic regions • Relevant contact information is included, such as location, fees, eligibility criteria and funding information for all programs and services in the database (e.g., MIPath and the Area Agency on Aging provide funding for individuals to complete self-management training) • Portion of database includes self-management training programs available in the community
10.3	Partnerships for collaboration with appropriate agencies and organizations are established at the Practice Unit level in conjunction with the PO • PO provides ongoing oversight and support to the Practice Unit in their collaborative efforts
10.4	All members of care team involved in establishing care treatment plans have received training on community resources so that they identify and refer patients appropriately • Training may occur in collaboration with community agencies, who will serve as subject-matter experts on local resources • PO or Practice Unit administrator will assess the competency of Practice Unit staff that are involved in the resource referral process
10.5	Systematic approach is in place for evaluating all patients for need for referral to community resources • Practice Units may develop an algorithm (or series of algorithms) to guide the referral process for their practice.
10.6	Systematic approach is in place for referring patients to community resources • Patients will have access to resources that are appropriate for their ethnicity, gender orientation, ability status, age, and religious preference, including resources that are available in other languages such as Spanish, Arabic, and American Sign Language, and resources available both locally and nationally • If Practice Units within a PO have a great deal of diversity within their patient population, the PO may amass specific information about services for those diverse patient groups. Practice Units may also share information about resources for diverse groups • PO may develop standardized patient referral materials for community resources, such as a "prescription form" or computer-generated printout

10.7	Systematic approach is in place for tracking referrals made by the resource provision team, and ensuring that patients complete the referral activity • Tracking care for high-risk patients should be a priority. Practice Units are encouraged to create a hierarchy to ensure that vital services (such as referrals to mental health providers) are being tracked appropriately
10.8	Systematic approach is in place for conducting follow-up with patients regarding any indicated next steps • Patients may be held partially responsible for the tracking process. For example, Practice Units may use technology such as Interactive Voice Response (IVR) for patients to report initial contact and completion, develop a "passport" that patients can have stamped when they complete trainings or attend a support group, or use existing disease registries such as WellCentive • Process will include mechanism to track if patients decline care and reasons care was not sought if possible.

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Self-Management Support Initiative: Capabilities/Tasks	
11.1	Practice Unit leaders and staff have been trained/educated and have comprehensive knowledge of self-management support concepts and techniques • motivational interviewing • assessment of health literacy • identification of medical obstacles to self-management • establishment of problem-solving strategies to overcome barriers of immediate concern to patients • systematic follow-up with patients
11.2	Self-management support is offered to all patients *with the chronic condition selected for initial focus* (based on need, suitability, and patient interest) • motivational interviewing • assessment of health literacy • identification of medical obstacles to self-management • establishment of problem-solving strategies to overcome barriers of immediate concern to patients
11.3	Systematic follow-up occurs for all patients *with the chronic condition selected for initial focus* who are engaged in self-management support to discuss action plans and goals and provide supportive reminders • Phone • Email • In person
11.4	Regular patient experience/satisfaction surveys (e.g., PACIC) are conducted for patients engaged in self-management support, to identify areas for improvement
11.5	Self-management support is offered to patients *with all chronic conditions* (based on need, suitability, and patient interest) • motivational interviewing • assessment of health literacy • identification of medical obstacles to self-management • establishment of problem-solving strategies to overcome barriers of immediate concern to patients
11.6	Systematic follow-up occurs for patients *with all chronic conditions* who are engaged in self-management support to discuss action plans and goals and provide supportive reminders • Phone • Email • In person
11.7	Support and guidance in establishing and working towards a self-management goal is offered to every patient, including well patients

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Patient Portal Initiative: Capabilities/Tasks	
12.1	Available vendor options for purchasing and implementing a patient portal system have been evaluated
12.2	PO has assessed liability and safety issues involved in maintaining a patient portal at any level and developed policies and procedures that allow for a safe and efficient exchange of information (e.g., by developing a policy around incorporating electronic communications into a patient's permanent hard-copy record, or prohibiting electronic communication for emergency situations, etc.) • Messages must be secure and HIPAA compliant
12.3	Capability is in place for patients to request appointments electronically
12.4	Capability is in place for patients to log results of self-administered tests (i.e., daily blood glucose levels) and to graph and analyze those results
12.5	Capability is in place to alert providers of self-administered patient data that indicates a potential health issue • "Flags" may be set using customized parameters for individuals based on their care needs
12.6	Capability is in place for patients and doctors to participate in E-visits • POs will develop and implement protocol for responding to patient messages/requests for e-visits in a consistent and timely manner (e.g., a triage system), using structured online tools
12.7	Capability is in place for providers to send automated care reminders, health education materials, links to community resources, educational websites and self-management materials to patients electronically
12.8	Capability is in place for patients to create a personal health record
12.9	Capability is in place for patients and providers to review test results, registries and electronic medical records online
12.10	Capability is in place for patients to request prescription renewals electronically

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Coordination of Care Initiative: Capabilities/Tasks		
	13.1	For every patient with chronic condition selected for initial focus, mechanism is established for being notified of each patient admit and discharge or other type of encounter, at facilities with which the PCMH physician has admitting privileges or other ongoing relationship • Standards for information exchange have been established to enable timely follow-up with patients
	13.2	Process is in place for sending necessary medical records and discussing continued care arrangements with other facilities for all patients *with chronic condition selected for initial focus* • Patients are encouraged to request that PCMH Practice Unit be notified of any patient encounter with health care facilities
	13.3	Systematic approach is in place to use patient registry to systematically track care coordination activities for each patient *with chronic condition selected for initial focus*. Fields are structured to allow care coordination across other settings of care as well. • Facility name • Admit date • Origin of admit (ED, referring physician, etc.) • Attending physician (if someone other than PCP) • Discharge date • Diagnostic findings • Pending tests • Treatment plans • Complications at discharge
	13.4	Systematic approach is in place to flag for immediate attention any patient registry data that indicates a potentially time-sensitive health issue for all patients *with chronic condition selected for initial focus*
	13.5	For patients leaving the practice (i.e., because they are moving, going into a nursing home, or choosing to leave the practice), written transition plans are developed in collaboration with patient and their caregivers for patients *with chronic condition selected for initial focus* • Patients are assited in finding a new primary care provider and/or specialists
	13.6	Capability is in place to coordinate care with health plan case manager(s) regarding extra-contractual benefits and services for all patients *with chronic condition selected for initial focus*
	13.7	All members of care team are adequately trained on care coordination processes as determined by each Practice Unit, and have clearly defined roles within that process • Practice Unit will develop written policies on how to communicate with patients/caregivers and how all coordination tasks will be delineated (e.g., using a flow chart)
	13.8	Care coordination capabilities are extended to *all patients with chronic conditions* that need care coordination assistance
	13.9	Care coordination capabilities are extended to *all patients* that need care coordination assistance

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Specialist Referral Process Initiative: Capabilities/Tasks	
14.1	Policies and processes are in place to guide each phase of the specialist referral process – including desired timeframes for information exchange - for specialists *within* the physician organization • Practice units will define goals around what constitutes a high-quality specialist referral process for their office (e.g., referring physician will assist patient with scheduling specialist appointment 100% of the time, referring physician will transfer patient information to specialist within 48 hours 100% of the time, etc.)
14.2	Policies and processes are in place to guide each phase of the specialist referral process – including desired timeframes for information exchange - for specialists *outside* the physician organization
14.3	Database is maintained of specialists to whom patients are referred, and Practice Unit evaluates patient satisfaction with those specialists at least annually, to ensure physicians refer patients to specialists that meet their standards for patient-centered care • Practice Units have defined and validated the criteria which are most important to them when referring patients to a specialist, and revise or update database of preferred physicians regularly • Practice Units ask specialists to evaluate the quality of information the Practice Units provide prior to the appointment, essentially asking the specialists, "are we giving you what you need?"
14.4	PO or Practice Unit has developed patient- and condition-specific standardized specialist referral materials • Basic information about the specialist, including name, office location and hours • Expectations about the specialist visit: e.g., consultation, test/procedure, transfer of responsibility for patient management • Expected duration of specialist involvement, if PCP is able to determine in advance • How quickly patient should see the specialist
14.5	Capability is in place for Practice Unit to make specialist appointments on behalf of patients
14.6	Capability is in place to automate each facet of the specialist referral process at the Practice Unit level by using electronically-based tools or changing processes, to avoid duplication of testing and prescribing across multiple care settings • Practice Units have built processes into existing patient registry or portal system, or utilize other tools (e.g. Fusion by CareFX) • Policies have been developed to ensure safe, HIPAA compliant information exchange for all information related to the specialist referral process • PCPs may encourage patients to report back on outcomes from the specialist visit at their next appointment, or ask the specialist to report back to the PCP about the visit.
14.7	Capability is in place to track whether or not patients completed the specialist referral in a timely manner - including whether or not they saw the specific specialist to whom they were referred - and reasons they did not seek care if applicable • Practice Units also track sub-specialist visits, i.e. referrals made by the specialist.
14.8	Relevant Practice Unit staff are adequately trained on all aspects of the specialist referral process Specialist