

CORE VALUE	LEVEL 1 <sup>1</sup>	LEVEL 2	LEVEL 3	COMMENT & Validation criteria
<p>1. Access to PCMH</p> <p>A. 24/7 availability*<sup>2</sup></p> <p>B. Continuous access to the patient record</p> <p>C. Same day scheduling available</p> <p>D. Expanded clinical hours</p> <p>E. Continuity demonstrated by % of total patient visits to PCMH. (To be PCMH at least 51% of your patients must make 51% of their visits to you.*)</p>	<p>Via phone</p> <p>Via FAX during clinic hours</p> <p>50% of days 4 hrs on eve or weekend</p> <p>51% of visits to PCMH</p>	<p>Questions can be answered 24/7</p> <p>Electronic access sent from PCMH during clinic hours</p> <p>75% of days 12 hours</p> <p>75%</p>	<p>Via phone plus written agreement with ED and same day FAX/electronic record transfer to/from ED and PCMH</p> <p>Electronic access 24/7</p> <p>95% of days 20 hours</p> <p>90%</p>	<p>Phone calls at off hours can validate L-2; written agreements available for L-3</p> <p>L-3 requires a repository or RHIO</p> <p>Validate via site schedules.</p> <p>Payer records can document this. Exception made for complex patients?</p>
<p>2. Patient/Family Centered</p> <p>A. Provides age/sex specific prevention material to patient/family</p> <p>B. Provides condition specific info sheets</p> <p>C. On line access</p> <p>D. Interpreter services if &gt; 5% of a language</p> <p>E. PCAT tool sample of 70 patients yearly (?)</p>	<p>No</p> <p>5 conditions</p> <p>To A &amp; B</p> <p>Language line</p> <p>Score of ??</p>	<p>Yes</p> <p>10 conditions</p> <p>To ask a question</p> <p>Onsite interpreter</p> <p>Score of ??</p>	<p>Yes</p> <p>More than 25</p> <p>To virtual visits</p> <p>Bilingual staff</p> <p>Score of ??</p>	<p>Utility could provide.</p> <p>Utility could provide.</p> <p>See footnote<sup>3</sup></p>

<sup>1</sup> An argument could be made that another approach to the “Level 1-2-3” scoring would be a continuous score from basic (see footnote 2, next) to a top score. To become certified you would only have to complete the Core Values assessment tool and meet the basic of footnote 2. Each additional point would carry with it an increase in financial support, apart from the fee for service payment. In other words, everyone could be “certified” but for it to have any meaning or reap any rewards you would have to progress along the continuum of Core Value improvements. If you wanted the certification to be transparent, you could attach the numeric score to the certification. Perhaps this would be too complicated but the competitive spirit might awaken and real progress appears.

<sup>2</sup> The items with an “\*” must be satisfied at level 1 to meet the definition of a PCMH.

<sup>3</sup> The Primary Care Assessment Tool is available in short and long forms for children and adults. It assesses the *patient’s* perspective on various aspects of PCMH.

<b>3. Comprehensive, coordinated services</b>				
A. Participation in Learning Collaborative	No	Once	Annual	Validate with attendance records Validate via written contract. Self validate, or payer evaluate. Self evaluate or payer evaluate  Validate by viewing log. Validate by response to a checklist
B. Hospital care provided or formally arranged	No	No	Direct provision or contract arrangement	
C. Medication list on chart	51%	75%	90%	
D. Identifiable team and evidence of its function	Team members listed	Notes in patient record from team members other than provider, 5% of charts.	Notes in patient record from team members other than provider 15% of charts	
E. Referral log	Paper log		Electronic log	
F. Practice provides care to majority (51%+) of acute and chronic conditions (adult &/or peds)*	Yes			

<b>4. Accountable care</b>				
A. Population health management	Paper log or insurer reporting of patients by group. 1 condition	3 conditions	Use of Registry or EHR with registry function. 5+ conditions	Validate via view of log/registry  Improvement is initially <i>from practice baseline</i> , not to a pre-defined benchmark. Potential outcome measures to be provided. <sup>4</sup>
B. Demonstrable improvement in a population's health				

<sup>4</sup> This is a key principle. It is extremely difficult to risk adjust in primary care. Providers *will* try to divest themselves of challenging patients as experience in California has shown. Moving from a grade of "D" to "C" is just as valuable as moving from "B" to "A" in population health.

C. Written performance improvement notes demonstrating use of data for performance improvement	Yearly	Quarterly	11/12 months	
5. <i>Accountable care, continued: Suggested health outcome measures.</i> <sup>5</sup>				Score is improvement over baseline for all of these. See footnote <sup>7</sup>
A. Immunization Rate in 2 year olds B. BMI of 5-6 yo in <i>community</i> <sup>6</sup> C. HbA1C >9.0 D. CHF admissions E. Oral Health measures F. Mental Health measures G. Etc.	IRIS score improves ??% Lowered ??% ??% improvement ??% decline	IRIS improves ??% Lowered ??% ??% improvement ??%decline	IRIS improves ??% Lowered ??% ??% improvement ??%decline	See footnote <sup>8</sup>

<sup>5</sup> This section may well belong in a pay for performance section, and not in a certification section. Note most are population focused. CMS “Meaningful Use Matrix” measures should be considered

<sup>6</sup> This goal would be measured across the community. To achieve compliance (or P4P) the entire community would have to show progress in lowering BMI. It is suggested that any lowering would be highly rewarded to all providers, emphasizing the long term importance of this indicator. It appears highly unlikely that a practice can lower the BMI, but a community intervention may well do so.

<sup>7</sup> IRIS has some well known shortcomings. Defining this as the reporting tool will force its improvement and emphasize the importance of the HIT connected PCP community.

<sup>8</sup> There is emerging controversy about how low to push the A1C. There is none about getting patients below 9.0