Click here to listen to presentation recording.

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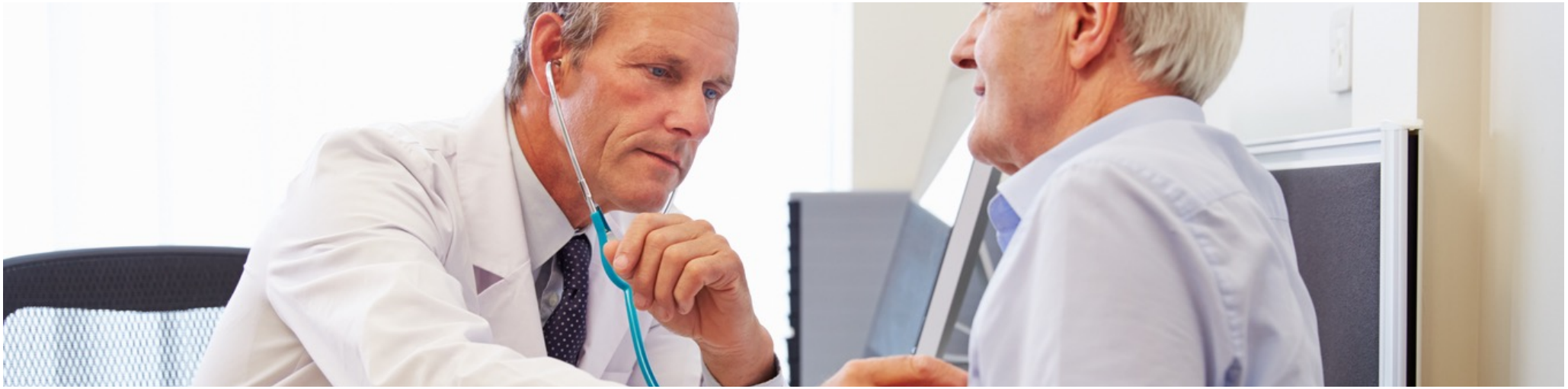


April 2021

Session 1

Patient Centered Medical Home: A Practice Model to Improve Quality

Kate Hill, VP Clinic Division

The Compliance Team™

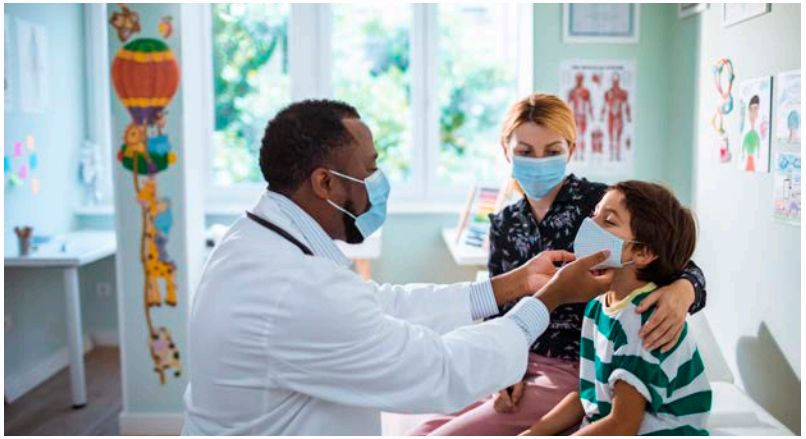
Introductions

Kate Hill, R.N.
VP of Clinical Division

Theresa Griffin Rossi
Program Development Advisor

The Compliance Team™

Session 1: Learning Objectives



- What is a Patient Centered Medical Home and 9 Compelling reasons to become one
- Orientation to PCMH
- Process for becoming a PCMH

REMINDER!

Register for Sessions 2 and 3 to complete the training series,
“Patient Centered Medical Home: A Practice Model to Improve Quality”

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What is a Patient Centered Medical Home?

The American Academy of Family Physicians defines a medical home as one that is based on the Joint Principles of the Patient-Centered Medical Home (PCMH), the Shared Principles of Primary Care, and the five key functions of advanced primary care. Through implementing medical home functions, you can improve the quality, effectiveness, and efficiency of the care you deliver while responding to each patient's unique needs and preferences.

The Patient-Centered Medical Home (aafp.org)

- The Agency for Healthcare Research and Quality (AHRQ) defines a medical home not simply as a place but as a model of the organization of primary care that delivers the core functions of primary healthcare.

Home | PCMH Resource Center (ahrq.gov)

- The patient-centered medical home (PCMH) is a model of care in which patients are engaged in a direct relationship with a chosen provider who coordinates a cooperative team of healthcare professionals, takes collective responsibility for the comprehensive integrated care provided to the patient, and advocates and arranges appropriate care with other qualified providers and community resources as needed.

Patient-Centered Medical Home:
What is a Patient-Centered Medical Home (PCMH)? | Primary Care Collaborative (pcpcc.org)

Definition of a PCMH – www.AAFP.org

1. **Access and Continuity** — Medical homes optimize continuity and timely, 24/7 first contact access care supported by the medical record. Practices track continuity of care by physician or panel.
2. **Planned Care and Population Health** — Medical homes proactively assess their patients to determine their needs and provide appropriate and timely chronic and preventive care, including medication management and review. Physicians develop a personalized plan of care for high-risk patients and use team-based approaches to meet patient needs efficiently.
3. **Care Management** — Care management has benefits for all patients, but patients with serious or multiple medical conditions benefit more significantly due to their needs for extra support to ensure they are getting the medical care and/or medications they need.
4. **Patient and Caregiver Engagement** — Medical homes engage patients and their families in decision-making in all aspects of care.
5. **Comprehensiveness and Coordination** — Primary care is the first point of contact for many patients, and therefore is the center of patients' experiences with health care.

Why Become a Patient Centered Medical Home?

CMS has moved to change how it structures payment from a quantity to a quality approach. It will provide incentives for better processes and outcomes. (unknown time frame for RHCs)

Medicaid programs have made enhanced payments to providers who achieved certain distinctions or process measures.

PCMH is a Value-Based Strategy

9 Compelling Reasons to Become a PCMH - TCT

1. Patient Engagement
2. Improved Outcomes
3. Decreased Emergency Department Use
4. Increase in Revenue
5. Decrease in Hospital Readmissions
6. Increase in Market Share
7. Increase in Staff Satisfaction
8. Increase in Patient Satisfaction
9. It's the Right Thing to Do

Refer to Session 1, Handout 1 outlining the 9 Compelling Reasons to Become a PCMH

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PCMH – Why is it important?

PCMH models provide evidence of consistent reductions in high-cost care that is often avoidable.

Why Become a PCMH?

It is different than a traditional PCP, being more patient and provider-friendly

Increased access to care responds to the real-life needs of patients in the community.

Patients are impowered and utilize fewer staff resources when they use customized self-management plans to achieve goals or manage their diseases

High-risk patients benefit, as pro-active coordination and follow-up communication by the Care Team saves them (and their caregivers) both time and money

Staff members report greater happiness when focusing on “what matters most” to the patient

Care Coordinators feel pride in collaborating with healthcare providers and community resources

Providers report satisfaction by keeping their most vulnerable patients out of the hospital

Care Team members function at their highest level, “to the top of their license or certificate”

PCMH Accreditation results in higher reimbursement from some payers

Differences between Traditional Care Models and PCMH

Traditional Method	PCMH
• Paper medical records	• EMR
• Minimal use of technology	• Evidence based decision support • Population health management • Electronic prescribing • Patient portals
• Providers allow managers to deal with the outside world	• Providers are actively engaged in conversations and plans for the patient's future • Providers take a lead role in community involvement
• Top down delegation	• Provider-staff meeting on a regular basis
• Too busy for regular meetings	• Huddles
• Providers meet without office representation	• Open door policy
• Staff meetings without providers	• Open discussion of ideas
• Focus on sickness	• Focus on health and wellness as well as sickness

Differences between Traditional Care Models and PCMH

• Communication and education provided to patients as needed	• Pro-active patient engagement and education • Patients receive and review PCHIP with provider • Alternate modes for delivering care such as group visits, phone management, nurse visits
• Barriers to patient access	• Open access for patients
• Referrals to specialists for chronic conditions	• Able to care for patients in the office for acute, chronic care and wellness care
• Reactive management of patient's preventative and chronic care	• Pro-active population management for chronic and preventative care
• Patients call for appointments after hospitalization	• Practice works closely with hospital when patient is hospitalized. Patients are pro-actively called after hospitalization
• Patients selects specialists as they feel the need	• Provider coordinates all care outside the office. Provider is informed and engaged in care outside of the office.
• Provider is primary or sole source for care	• Multidisciplinary team is the source of care
• Patient satisfaction might be measured once a year	• Consistent Quality improvement measures and methods

PCMH – Session 1, Handout 2

Refer to Session 1, Handout 2

"Differences between Traditional Care Models and PCMH" to initiate discussion with your team.

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Barriers to Becoming a Patient Centered Medical Home

Resistance to change

Inadequate financial resources

Low workforce

Low adaptive reserve

Your EHR

Staff buy in

Motivation

Some PCMH Programs can be…

Rigid

Burdensome

Labor Intensive

Expensive

Overwhelming

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Rethinking PCMH

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

We believe the primary focus should be centered around patient care.

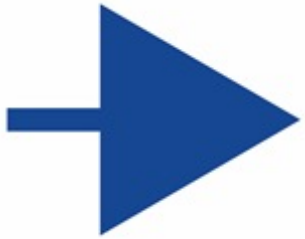
Efficiency in daily operations allows providers to concentrate on “What Matters Most”, the patient!

Its a Winning Approach for both Clinics and Patients.

The Benefits of PCMH

Benefits of PCMH

Comprehensive Care
Patient-Centered Care
Coordinated Care
Assessible Services
Quality and Safety



Reduced Emergency Department Visits
Reduced Hospital Re-admissions
Reduced Hospital Admissions for Chronic Disease
Increased Preventive Screening
Reduction in High-Cost Avoidable Care

Improvement not Transformation!

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The Quadruple Aim

The PCMH model ties in with the “Quadruple Aim”

Enhancing patient experience

Improving population health

Reducing overall healthcare costs

Improving the work life of health care providers

How Does PCMH Benefit My Clinic?

As an Exemplary Provider, you demonstrate to Federal and State regulatory agencies, payors, and the community at large that you deliver exceptional, safe, and quality care. Recognition is key to reimbursement and payors respond.

What are payors looking for? Data driven outcomes that lower cost.

How does PCMH Benefit My Patients?

Examples of PCMH patient care improvements:

- Same day appointments for urgent illness and expanded appointment hours
- A specific plan to handle all types of patient communication
- After-hours triage service and phone access to an on-call provider
- Implementation of a team-based approach to coordinated care
- Assigned care coordinator who develops relationships with patients and provides direct access to the care team

Are There Any Benefits for Staff?

Staff satisfaction:

PCMH provides rewards not just to the patients but also to your providers and staff when everyone is engaged and truly understands the 'why' behind the model. In talking with clinics currently designated as patient centered medical homes, staff engagement was often cited as the hardest hurdle to accomplish.

However once PCMH was fully implemented, most clinics report a much higher level of provider/staff satisfaction along with higher patient satisfaction ratings.

Testimonials – Quotes From Our Clinics

"Our patients feel more connected because of all the additional contact. That translated to a feeling that Our patients interpret this to mean we care more than we did"

"We focus on patient management during transitions of care to decrease readmission; scheduled, proactive outreach to high-risk patients; and initiatives that support patient self-management of chronic diseases."

"We receive a daily census of our admitted patients from hospitals. One of the hospitals automatically sends Emergency Dept., H&P, consult and discharge reports for each transition. Those reports are faxed, and the MAs ensure timely transfer of data to tracking spreadsheets."

"I interview the patient and family and figure out the holistic needs of the patient. Spending time with outreach programs arranging transportation and Meals on Wheels can make a difference in keeping a chronically ill patient out of the hospital. Its not always medication management,"

"I feel like a nurse again"

"Great medicine is being done outside the patient visit, mostly in follow up activities"

Session 1, Part 2

Orientation to TCT PCMH Program And Accreditation Timeline

Patient Centered Medical Home: A Practice Model to Improve Quality

Kate Hill, VP Clinic Division

The Compliance Team™

Disclaimer: PCMH Accreditation

For the purposes of this training, content, templates and accreditation information provided is exclusive to The Compliance Team Patient Centered Medical Home Program.

PCMH accreditation is offered by other accreditors and your clinic may want to research options before deciding which program best fits your needs.

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TheComplianceTeam™ Exemplary Provider® Accreditation

TCT Approach to PCMH

"Simplification leads to clarity and clarity allows the provider to focus on what matters most to the patient!"

Sandy Canally, RN TCT CEO and Founder

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Navigating the PCMH Journey

Orientation

- Orientation Call
- PCMH Training Calls (2)
- Universal and Specialty Standards Call (1)
- View Clinical Concerns webinar (on TCT website)

Preparation

- Address EHR templating early in process
- Utilize templates on TCT website for policies and protocols
- Use PCMH checklist to track progress and organize policy binder
- Conduct a self survey with the PCMH checklist

Pre-survey

- Submit all required documents to TCT (see document checklist)
- Send completed HR audit in Word format (not PDF)
- Complete TCT Onsite Ready form (OSSR) signaling readiness for survey
- Remind clinic staff that survey date is immanent

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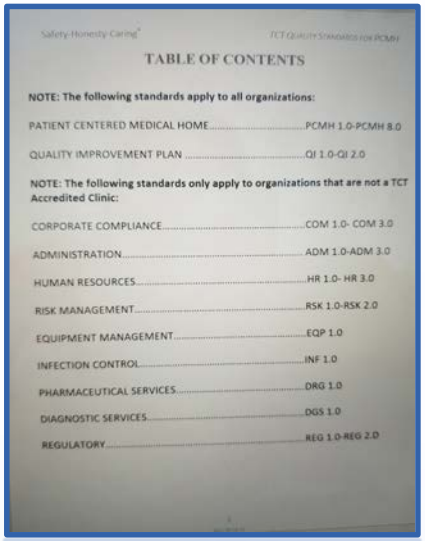
Difference between PCP and TCT RHC Accredited?



Answer:
Universal and Specialty Standards

- TCT RHC accredited clinics have already complied with Universal and Specialty standards as part of the RHC accreditation process
- PCMH standards include these additional standards as part of the process

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Preparation Timeline

What is a Realistic Goal for Survey Readiness?

At a Minimum:
90 Days Preparation
is Recommended.

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Path for Primary Care Practices

Advisor Calls:

1) Orientation Call
2) Review Standards PCMH 1.0 – PCMH 5.0
3) Review Standards PCMH 6.0 – PCMH 8.0 and QI 1-0-2.0
4) Review Universal and Specialty Standards
5) Q & A

View Clinical Concerns Webinar Independently

Work PCMH Checklist to Identify Areas Where Clarification or Increased Resources are Needed

Schedule Follow-Up Calls to Evaluate Progress

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Path for TCT Accredited RHCs

Advisor Calls:

1) Orientation Call
2) Review Standards PCMH 1.0 – PCMH 5.0
3) Review Standards PCMH 6.0 – PCMH 8.0 and QI 1.0-2.0
4) Q & A
5) Follow up calls to evaluate progress

View Clinical Concerns Webinar Independently

Work PCMH Checklist to Identify Areas Where Clarification or Increased Resources are Needed

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Who Should Be On The PCMH Implementation Team?

At a Minimum:
Clinic/Practice Manager and Care Coordinator

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Successful Implementation Teams…

- Read the Standards before Training
- Communicate with Facilitator (if using one)
- Attend Training Calls ASAP
- Develop an Implementation Plan and Timeline
- Find Provider Champion(s)
- Invite Other Staff to Participate
- Delegate Duties and Set Deadlines
- Utilize TCT Web Templates and Webinars
- Work Out EHR Re-Writes Early On
- Develop an Accreditation Portfolio
- Read About PCMH Innovation
- Reach Out to other Practices

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Ensure the Team is Working with the Right Set of PCMH Standards

Look for “REV. 10.19.20”
lower left corner of page

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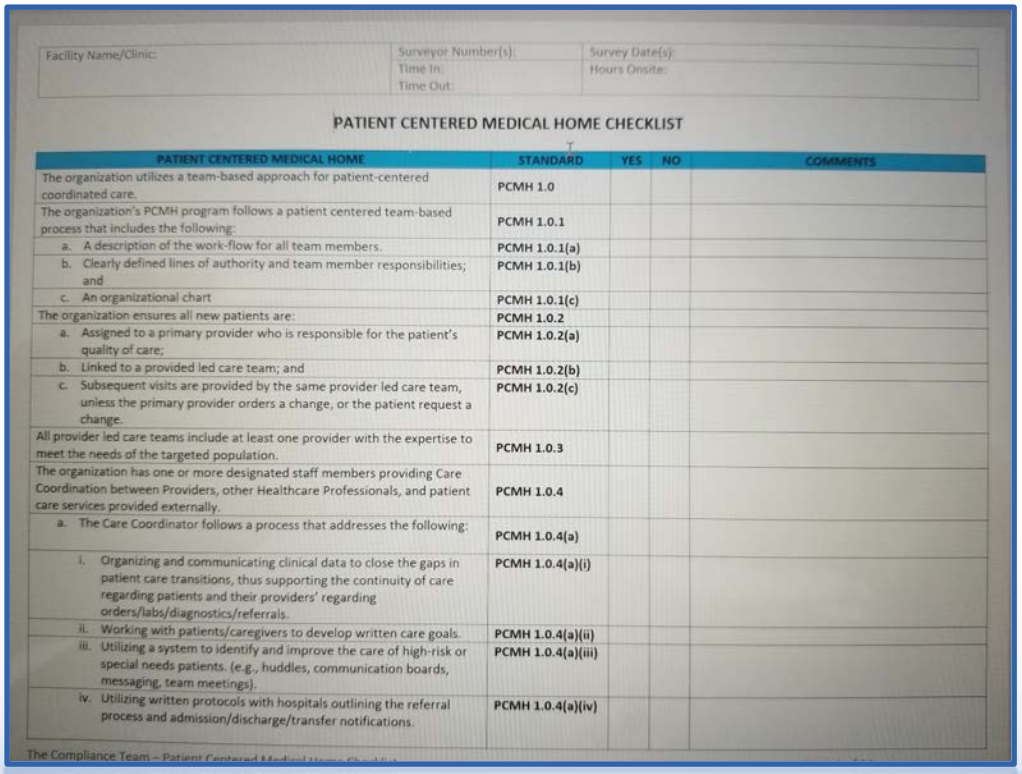
TCT Checklist

Aqua Headers



Facility Name/Clinic:	Surveyor Number(s): Time In: Time Out:	Survey Date(s): Hours Onsite:

PATIENT CENTERED MEDICAL HOME CHECKLIST

PATIENT CENTERED MEDICAL HOME	STANDARD	YES	NO	COMMENTS
The organization utilizes a team-based approach for patient-centered coordinated care.	PCMH 1.0			
The organization's PCMH program follows a patient centered team-based process that includes the following:	PCMH 1.0.1			
a. A description of the work-flow for all team members.	PCMH 1.0.1(a)			
b. Clearly defined lines of authority and team member responsibilities; and	PCMH 1.0.1(b)			
c. An organizational chart	PCMH 1.0.1(c)			
The organization ensures all new patients are:	PCMH 1.0.2			
a. Assigned to a primary provider who is responsible for the patient's quality of care;	PCMH 1.0.2(a)			
b. Linked to a provided led care team; and	PCMH 1.0.2(b)			
c. Subsequent visits are provided by the same provider led care team, unless the primary provider orders a change, or the patient request a change.	PCMH 1.0.2(c)			
All provider led care teams include at least one provider with the expertise to meet the needs of the targeted population.	PCMH 1.0.3			
The organization has one or more designated staff members providing Care Coordination between Providers, other Healthcare Professionals, and patient care services provided externally.	PCMH 1.0.4			
a. The Care Coordinator follows a process that addresses the following:	PCMH 1.0.4(a)			
i. Organizing and communicating clinical data to close the gaps in patient care transitions, thus supporting the continuity of care regarding patients and their providers' regarding orders/labs/diagnostics/referrals.	PCMH 1.0.4(a)(i)			
ii. Working with patients/caregivers to develop written care goals.	PCMH 1.0.4(a)(ii)			
iii. Utilizing a system to identify and improve the care of high-risk or special needs patients. (e.g., huddles, communication boards, messaging, team meetings).	PCMH 1.0.4(a)(iii)			
iv. Utilizing written protocols with hospitals outlining the referral process and admission/discharge/transfer notifications.	PCMH 1.0.4(a)(iv)			

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Session 1, Handout 3

Take time to read the standards!

- ✓ What are you already doing?
- ✓ What areas do you need to focus on to meet the PCMH requirements?
- ✓ Develop a plan for preparation and implementation of the PCMH model.
- ✓ Prep staff for changes in advance and educate them on why PCMH is important to the practice.

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Resources

Available as part of the accreditation package, TCT has a wide range of resources for the Patient Centered Medical Home program including:

Webinars

Templates for Policies and Procedures

Patient Satisfaction Survey Portal

Quality Measures Portal

Individual support with an Accreditation Advisor

**Important to Note: Other accreditors have developed their own PCMH standards and resources may or may not be provided.

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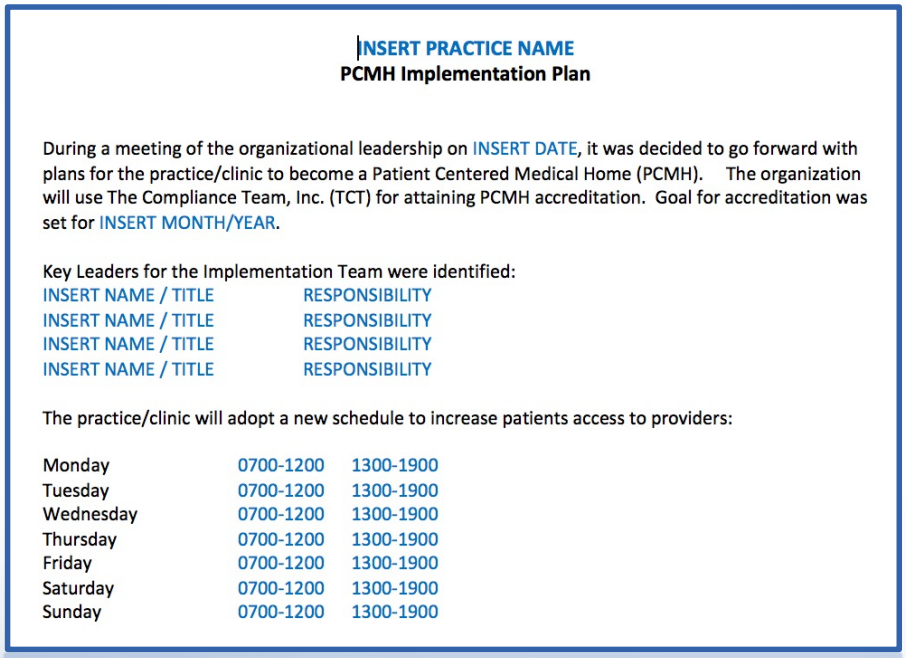
Resources: Sample PCMH Templates



INSERT PRACTICE NAME
PCMH Implementation Plan

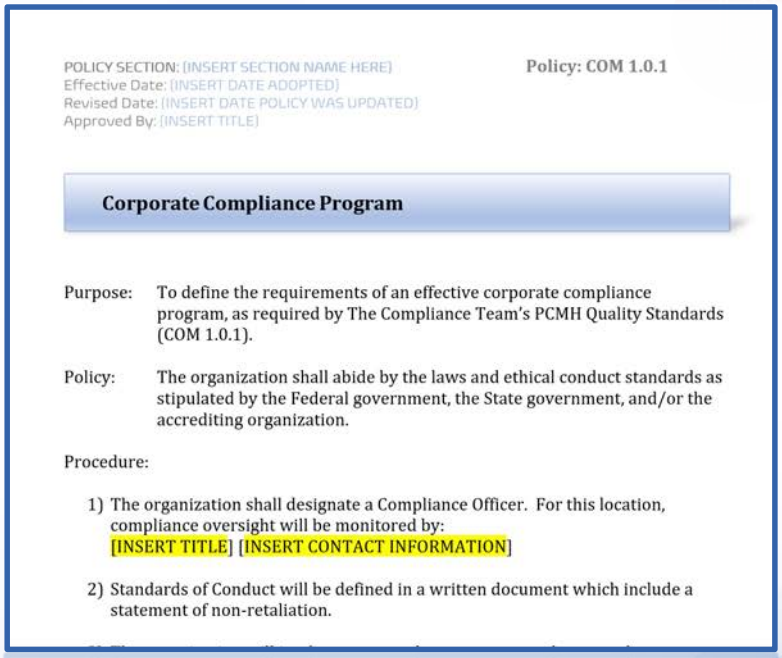
During a meeting of the organizational leadership on INSERT DATE, it was decided to go forward with plans for the practice/clinic to become a Patient Centered Medical Home (PCMH). The organization will use The Compliance Team, Inc. (TCT) for attaining PCMH accreditation. Goal for accreditation was set for INSERT MONTH/YEAR.

Key Leaders for the Implementation Team were identified:

INSERT NAME / TITLE	RESPONSIBILITY
INSERT NAME / TITLE	RESPONSIBILITY
INSERT NAME / TITLE	RESPONSIBILITY
INSERT NAME / TITLE	RESPONSIBILITY

The practice/clinic will adopt a new schedule to increase patients access to providers:

Monday	0700-1200	1300-1900
Tuesday	0700-1200	1300-1900
Wednesday	0700-1200	1300-1900
Thursday	0700-1200	1300-1900
Friday	0700-1200	1300-1900
Saturday	0700-1200	1300-1900
Sunday	0700-1200	1300-1900



POLICY SECTION: (INSERT SECTION NAME HERE)
Effective Date: (INSERT DATE ADOPTED)
Revised Date: (INSERT DATE POLICY WAS UPDATED)
Approved By: (INSERT TITLE)

Policy: COM 1.0.1

Corporate Compliance Program

Purpose: To define the requirements of an effective corporate compliance program, as required by The Compliance Team's PCMH Quality Standards (COM 1.0.1).

Policy: The organization shall abide by the laws and ethical conduct standards as stipulated by the Federal government, the State government, and/or the accrediting organization.

Procedure:

1) The organization shall designate a Compliance Officer. For this location, compliance oversight will be monitored by:
[INSERT TITLE] [INSERT CONTACT INFORMATION]

2) Standards of Conduct will be defined in a written document which include a statement of non-retaliation.

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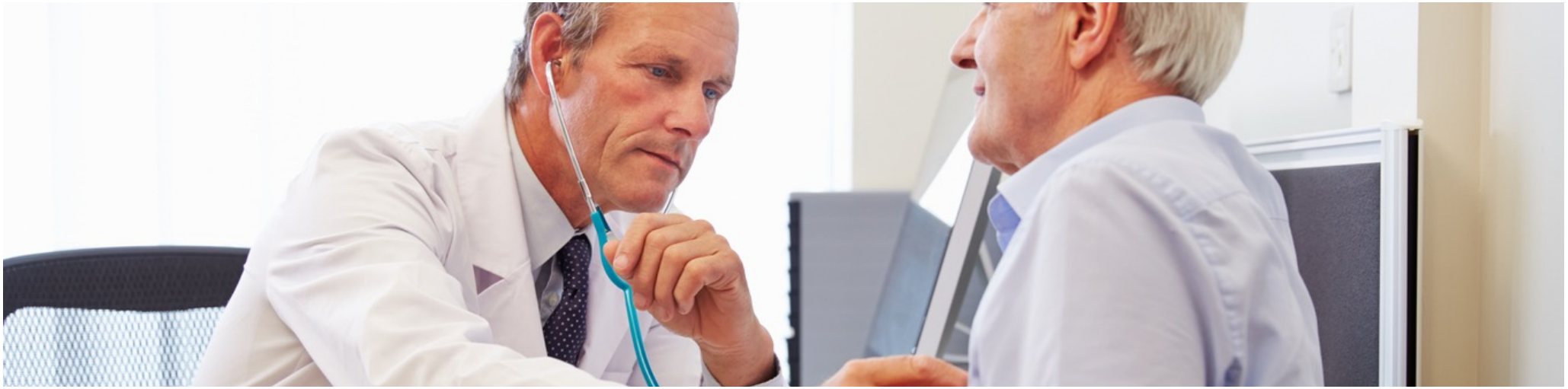

The Process: Becoming a PCMH

Patient Centered Medical Home: A Practice Model to Improve Quality

Session 1 Part Three

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The Journey starts with a Vision…

To foster a team-based patient care approach.

To provide better access for patients.

To deliver patient care based on a coordinated care plan (PCHIP).

To embrace a patient centered delivery method that focuses on “What Matters Most” to the patient.

To offer community resources that provide socio-economic support to the patient.

To promote data driven quality improvement that enhance patient care practices.

To decrease cost by lowering after hours use of emergency department and reducing hospital readmissions.

To elevate patient healthcare by adhering to the PCMH quality standards and becoming a PCMH Exemplary Provider.

The Process: Overview

Application and payment
Welcome Packet
Meet Your Accreditation Advisor
Orientation and Training Calls
Webinars and Other Resources
Preparing for the Onsite Visit
Onsite Ready! Filing your OSSR
Onsite Survey Day
Compliance, Deficiencies and Plan of Correction
Achieving Exemplary Provider Status
Congratulations! You are a recognized Patient Centered Medical Home
Reporting Requirements
Maintaining Accreditation

The Process: Steps to Success

- ✓ complete the application
- ✓ submit required documents
- ✓ kick off meeting with staff – find a PCMH champion!
- ✓ complete training calls with your accreditation advisor
- ✓ define your timeline and develop a preparation/implementation plan
- ✓ customize the required policies and procedures
- ✓ Work your implementation plan and identify areas that need attention
- ✓ Q&A with a call advisor
- ✓ perform a mock survey
- ✓ final review of policies and procedures for completion
- ✓ complete the onsite ready form
- ✓ onsite visit scheduled

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Quality Standards

Two tracks – Which one are you?

PCMH Standards for Primary Care Practices

PCMH Standards for TCT Accredited RHCs

Knowledge is Power – Standards are the foundation of the Program

Understanding Compliance – The Who, What, Where, When, and How

The Standards Checklist – Your Tool for Success

- ✓ HR Audit Form,
- ✓ Policy Checklist,
- ✓ Medical Record Audit Form

Preparation and Implementation Plan

Conducting a Self-Evaluation, A.K.A “The Mock Survey”

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First Steps First – Read the Standards

Knowledge is a powerful tool and understanding the PCMH model is only the beginning.

The next important step is read AND re-read the PCMH standards. Have a good working knowledge of the requirements before you begin.

When you have the first call with your Accreditation Advisor:

- ✓ Be ready to ask questions
- ✓ Ask for clarification if you are unsure of the intent of a standard
- ✓ Begin to formulate a preparation and implementation plan based off standards
- ✓ What are you doing already? What are you not doing? What needs to be part of your plan to initiate with staff?

Understanding Compliance – The "Who, What, Where, When and How"

Who is responsible?

What are they responsible for?

Where does it take place?

When does it take place?

How does it meet the requirement?

Example: Monthly Medication Inventory

Per the clinic policy, monthly medication inventory dictates that:

Who: The RN along with one qualified staff member…

What: …is responsible for conducting the monthly medication inventory…

Where: …in all areas where medications are stored including medication room, exam rooms, emergency box and medication samples closet…

When: …on the first Friday of every month…

How: …and will document, sign and date the monthly medication inventory sheet and place in a binder labeled "Monthly Medication Inventory" stored in a secure location. All outdated medications will be disposed of per clinic policy on disposal of outdated medications.

Utilizing the Standards and Checklist to develop a preparation and implementation plan

The survey is an open book test. Use the standards and checklist to develop a plan to prepare the clinic to become a PCMH and to implement the process.

Important areas to pay close attention are:

EMR

Expanded Hours

Care Coordinator

Patient Care Teams

Patient Care Plans and Education:
Do we set goals with patients and educate them on their diagnosis?

Community Resources:
Do we have a list of community resources available for patients in need?

EMR and HIPAA Compliance

Is your EMR system PCMH compatible?

Pharmacy information and care coordination notes?

Does EMR have HIPAA compliant functions?

Time out to protect PHI?

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Expanded Hours:

Do you currently provide expanded hours to fit the needs of your patients?

How will you expand hours of operation?

How will you implement for provider/staff coverage?

Care Coordinator

Do you currently have a Care Coordinator/Navigator?

If not, who will be responsible?

Patient Care Teams:

Do you currently identify patient care teams?

Do you conduct daily team huddles?

Provide coordinated patient care?

Patient Care Plans and Education

Do you discuss “What Matters Most” with the patient and set health goals?

Do you develop a Patient Care Plan? We call them PCHIPS!

Do you provide education regarding diagnosis and treatment?

Community Resources

Do you discuss socio-economic determinants with your patients that may impact their health?

Do you provide information to your patients regarding community resources available to them?

The PCMH Model is…

"a different experience of the primary care relationship"

Managing patient's in-between encounters as we follow up, follow up, and follow up again to craft beneficial outcomes for high-risk patients.

THE POWER OF INTEGRATION…
A system of caring delivered at a community level.

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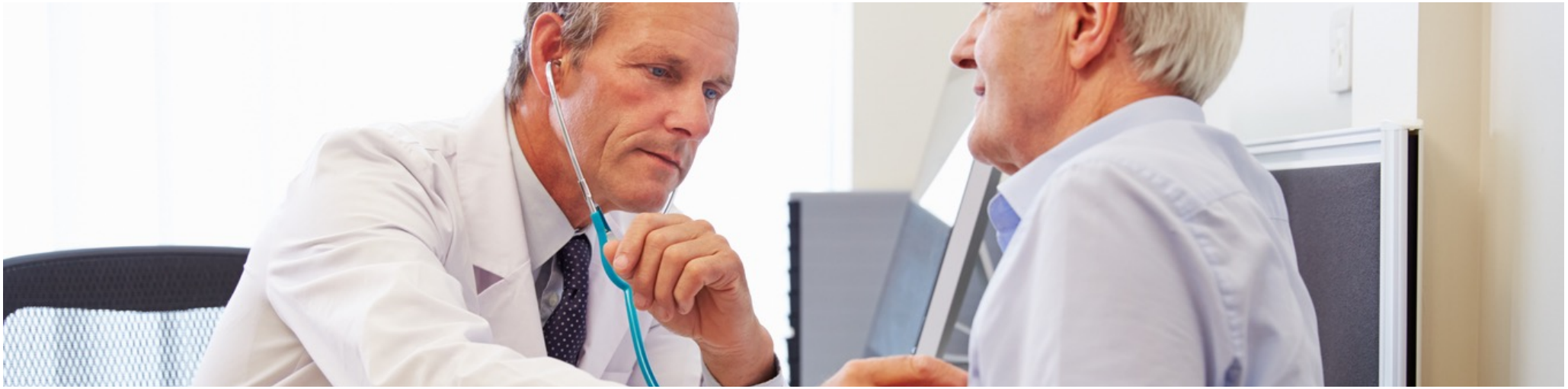

Advisor Perspective

A Discussion with a PCMH Call Advisor

April 2021

The Compliance Team™

Thank You For All You Do!

The Compliance Team™

Join us on

Wednesday, April 7,2021 for Session 2!

Thank you!

QUESTIONS?

Kate Hill, RN, VP Clinic Division
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TheComplianceTeam™ Exemplary Provider® Accreditation

Definition of a Patient Centered Medical Home (AHRQ.gov)

The patient-centered medical home (PCMH) is a model of care in which patients are engaged in a direct relationship with a chosen provider who coordinates a cooperative team of healthcare professionals, takes collective responsibility for the comprehensive integrated care provided to the patient, and advocates and arranges appropriate care with other qualified providers and community resources as needed.

9 Compelling Reasons to Become a Patient Centered Medical Home - TCT

1. Patient Engagement
    - Patients empowered and utilize fewer staff resources
    - Support for chronic disease
    - 24/7 patient access to care and health information
2. Improved Outcomes
    - "A care coordination patient, who is a diabetic and had an A1C over 11. She worked with me and Kathleen (Dietician). She now has lost over 30 pounds, decreased her meds, and her A1C is 6.7 in just 12 months of work! The patient is still in the program, and tells us all the time, that we are the reason she has been able to regain her health." ~ testimonial
3. Decreased Emergency Department Use
    - High-risk patients benefit, as pro-active coordination and follow-up communication by the Care Team saves them (and their caregivers) both time and money.
4. Increase in Revenue
    - PCMH Accreditation results in higher reimbursement from some payers.
5. Decrease in Hospital Readmissions
    - Providers report satisfaction by keeping their most vulnerable patients out of the hospital.
    - 51% of prescriptions written last year were either not filled or used incorrectly.

        How important is that call within 24 hours of hospital discharge?
6. Increase in Market Share
    - Be the Providers of choice in your neighborhood
7. Increase in Staff Satisfaction
    - Staff members report greater happiness when focusing on "what matters most" to the patient.
    - Care Coordinators feel pride in collaborating with healthcare providers and community resources.
    - Care Team members function at their highest level, "to the top of their license or certificate".
8. Increase in Patient Satisfaction

    Patients report:
    - 24/7 access to care and health information
    - Timely or same day appointments
    - Patients feel like we care about them

- Increased education on health matters
- Feeling empowered
- Getting help when they need it
- Receiving more attention

9. It's the Right Thing to Do
    - It's why we went into this work
    - It is different from a traditional PCP, being more patient and provider-friendly.

PCMH: A Practice Model to Improve Quality
Session 1, Handout 2

Traditional Method	PCMH
• Paper medical records	• EMR
• Minimal use of technology	• Evidence based decision support • Population health management • Electronic prescribing • Patient portals
• Providers allow managers to deal with the outside world	• Providers are actively engaged in conversations and plans for the patient's future • Providers take a lead role in community involvement
• Top down delegation	• Provider-staff meeting on a regular basis
• Too busy for regular meetings	• Huddles
• Providers meet without office representation	• Open door policy
• Staff meetings without providers	• Open discussion of ideas
• Focus on sickness	• Focus on health and wellness as well as sickness
• Communication and education provided to patients as needed	• Pro-active patient engagement and education • Patients receive and review PCHIP with provider • Alternate modes for delivering care such as group visits, phone management, nurse visits
• Barriers to patient access	• Open access for patients
• Referrals to specialists for chronic conditions	• Able to care for patients in the office for acute, chronic care and wellness care
• Reactive management of patient's preventative and chronic care	• Pro-active population management for chronic and preventative care
• Patients call for appointments after hospitalization	• Practice works closely with hospital when patient is hospitalized. Patients are pro-actively called after hospitalization
• Patients selects specialists as they feel the need	• Provider coordinates all care outside the office. Provider is informed and engaged in care outside of the office.
• Provider is primary or sole source for care	• Multidisciplinary team is the source of care
• Patient satisfaction might be measured once a year	• Consistent Quality improvement measures and methods

Exemplary Provider® Accreditation Program

SAFETY-HONESTY-CARING®

Quality Standards and Evidence of Compliance

Patient Centered Medical Home Standards

TABLE OF CONTENTS

NOTE: The following standards apply to all organizations:

NOTE: The following standards only apply to organizations that are not a TCT Accredited Clinic:

PATIENT CENTERED MEDICAL HOME

PCMH 1.0 The organization utilizes a team-based approach for patient-centered coordinated care.

EVIDENCE OF COMPLIANCE

1. The organization's PCMH program follows a patient centered team based process that includes the following:
    a. A description of the work-flow for all team members.
    b. Clearly defined lines of authority and team member responsibilities; and
    c. An organizational chart.

2. The organization ensures all new patients are:
    a. Assigned to a primary provider who is responsible for the patient's quality of care;
    b. Linked to a provided led care team; and
    c. Subsequent visits are provided by the same provider led care team, unless the primary provider orders a change, or the patient request a change.

3. All provider led care teams include at least one provider with the expertise to meet the needs of the targeted population.

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

    a. The Care Coordinator follows a process that addresses the following:

        i. Organizing and communicating clinical data to close the gaps in patient care transitions, thus supporting the continuity of care regarding patients and their providers' regarding orders/labs/diagnostics/referrals.

        ii. Working with patients/caregivers to develop written care goals.

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

        iv. Utilizing written protocols with hospitals outlining the referral process and admission/discharge/transfer notifications.

PATIENT CENTERED MEDICAL HOME

v. Providing a summary for patients transferring to another medical provider.

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

vii. Transition Care Management Services (as applicable).

5. The Care Coordinator monitors care provided to patients by other providers including:

   a. Specialists managing patient medications, ordering labs, diagnostics, treatments, procedures, and/or therapies.

   b. Pharmacists regarding patient medication history, adherence, and any involvement with medication therapy management.

PCMH 2.0	**The organization utilizes a Patient Centered Health Improvement Plan™ (PCHIP™) for those patients whose care needs to be managed and coordinated.**

EVIDENCE OF COMPLIANCE

1. The organization follows a written policy and procedure for developing Patient-Centered Health Improvement Plans™ (PCHIP™) that address the current and future needs of the patient from a whole person perspective. This policy describes how the Care Team will:

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

   b. Provide patient communication and education to meet the unique needs of each patient. The PCHIP™ must address the following communication needs of the patient, if applicable:

      i. When a physical or mental impairment or learning disability exists;

      ii. When English is not the primary language spoken; or

      iii. When cultural or religious beliefs may impact the delivery of care.

   c. When appropriate, include a patient's needs assessment concerning his/her ability to perform the activities of daily living, safety of the home environment, family/caregiver support, access to transportation, and other requirements for healthcare or support services that cannot be met by the organization.

PATIENT CENTERED MEDICAL HOME

d. Utilize a questionnaire or interview technique to identify and update the healthcare goal(s) most important from the patient's perspective. This questionnaire or interview determines the current limitations and frustrations that interfere with "what matters most" to the patient at this time in their life.

e. When appropriate, incorporate end-of-life or palliative care planning.

2. Evidence exists that all members of the care team are trained to assess and address the needs of the patient from a whole patient perspective. Training addresses the following:

a. The forms of communication and/or resources that allow for meaningful healthcare interactions and education;

b. Language and cultural competency;

c. Indicators that prompt social support discussions and referrals;

d. Short and long-term goal planning; and

e. Indicators that prompt end-of-life or palliative care discussions.

PCMH 3.0 The organization provides patient education and self-management tools to patients and their family/caregivers.

EVIDENCE OF COMPLIANCE

1. The organization provides patients, or when appropriate, the patient's representative (as allowed under State law) and their family/caregivers healthcare education and self-management tools when health problems are diagnosed, treatment is ordered, or risks are identified.

2. Evidence exists in the patient's healthcare record that the patient and their family/caregivers were provided healthcare education and self-management tools .

PATIENT CENTERED MEDICAL HOME

PCMH 4.0 The organization provides advanced access to its patients.

EVIDENCE OF COMPLIANCE

1. The organization's provides advanced access by expanding hours of operation beyond traditional appointment hours. Increased patient access includes:
   a. Same day appointments for urgent illness;
   b. Evidence of expanded weekday, evening, and/or weekend appointment offerings; and
   c. Call coverage or arrangement for after-hours emergencies twenty-four hours a day and seven days a week.
2. The organization provides patients and their family/caregivers written information regarding the Patient-Centered Medical Home and its services. This information is available in the language(s) of the community served.
3. The organization communicates essential practice information to its patients. This information includes:
   a. What patients should bring to each appointment;
   b. How patient calls and prescription requests are handled;
   c. The routes in which patients can attain healthcare access after-hours; and
   d. Policies regarding the rescheduling or cancellation of appointments.
4. Evidence exists of advanced access through multiple forms of communication with its patients.
5. The organization follows a written plan for handling patient communication that includes acceptable time frames (as determined by organizational policy) for returning patient calls or requests. All calls or requests from patients are documented with a date and time.
6. Evidence exists that the organization actively engages with community resources to reach out to its patient population.

PATIENT CENTERED MEDICAL HOME

PCMH 5.0 The organization provides patient follow-up.

EVIDENCE OF COMPLIANCE

1. To ensure continuity of care, the organization has a written policy and procedure for follow-up of their patients. The policy includes information on how the clinic provides follow-up information for:
    a. Missed patient appointments.
    b. Requests for medication refills by patients.
    c. High-risk medication(s) or in-home treatment(s) that are newly prescribed.
    d. Laboratory or diagnostic results.
    e. Referrals and consultations.
    f. Preventative care and screening reminders.
    g. Care coordination activities.
    h. Frequent use of the emergency department.
    i. Discharge from the hospital.
2. Evidence of follow-up communication with patients exists in the patient health record.

PCMH 6.0 The organization meets the healthcare needs of patients when they are closed.

EVIDENCE OF COMPLIANCE

1. The organization has a written agreement with each contracted healthcare entity responsible for handling the needs of patient's after-hours. The agreement identifies the contracted provider's scope of services, HIPPA compliance, responsibilities for patient care, and after-hours of operation.

PATIENT CENTERED MEDICAL HOME

2. The organization's providers receive and review patient healthcare information from after-hours providers and evidence of this follow-up is documented in the patient health record.

3. The organization has a comprehensive process that provides patients the ability to communicate their healthcare needs after-hours.

PCMH 7.0 The organization takes steps to reduce unnecessary utilization of services.

EVIDENCE OF COMPLIANCE

1. To improve the efficiency in the delivery of care provided, the organization follows a written plan that prevents over utilization of services. This plan includes implementation of the following waste reduction initiatives:
    a. Reducing avoidable patient emergency department (ED) visits;
    b. Reducing patient hospital re-admissions; and
    c. Offering same-day appointments.
2. Evidence exists that the organization reports data on the following utilization of services quarterly to The Compliance Team:
    a. Number of patients requiring care coordination,
    b. Number of ED visits,
    c. Number of avoidable ED visits,
    d. Number of hospital admissions, and
    e. Number of hospital readmissions.

PCMH 8.0 The organization ensures patient health records are complete.

EVIDENCE OF COMPLIANCE

1. The organization's patient health records have evidence of:

PATIENT CENTERED MEDICAL HOME

a. Patient identification and social data that includes:

    i. Identification of the individual(s) included in the care and/or healthcare decisions of the patient; and

    ii. The preferred language to be used for healthcare discussions with patient's family members and caregivers.

b. Written consent to treat for initiation of care. Properly executed patient consents include:

    i. Date and time along with appropriate signature.

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

c. Patient status regarding Advanced Directive, when appropriate:

    i. The organization asks the patient if they have an Advanced Directive.

    ii. If the patient does not have an Advanced Directive, the organization has evidence that the patient, or when appropriate, the patient's representative, was asked if they would like information.

d. Pertinent medical history.

e. Evaluation of current health status, which includes:

    i. Vital signs;

    ii. Gender, height, weight, and assessment of body mass index (BMI) or growth percentile;

    iii. Chief complaint;

    iv. Behavioral health screening when depressive symptoms are identified (e.g., Patient Health Questionnaire (PHQ 2 or 9) or another recognized tool);

    v. Cognitive health screening when symptoms are identified or if the patient is over 65 years of age (e.g., Brief Interview of Mental Status (BIMS) or another recognized tool);

    vi. Preventive-health measures;

    vii. Updated needs assessment (as appropriate);

PATIENT CENTERED MEDICAL HOME

viii. Updated Patient-Centered Health Improvement Plan™ (PCHIP™) as appropriate and defined by the organization) ; and

ix. Updated patient health goals (as appropriate and defined by the organization).

f. Summary of the encounter and patient instructions.

g. Reports, consultation notes, and any information pertinent to monitor the patient's progress.

h. Provider orders and documentation of tests, treatments, or medications administered in the practice setting.

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

j. Signature of the provider and date related to the encounter.

k. Identification of provider/care team assigned to the patient.

l. Identification of patient's pharmacy by name, location, and contact information. Note: Information may not be an individual field in electronic EMR but can be located in electronic prescribing software such as Escript.

2. Patients are provided with a printed after-visit summary or it is available to them via the organization's patient portal. Note: If summaries are not provided to patients at checkout, the organization monitors the percentage of patients utilizing the portal to ensure this information is being utilized by their population. The after-visit summary includes:

a. Current vital signs;

b. Relevant health data;

c. Current diagnosis;

d. Current medications;

e. Important patient instructions;

f. Patient's short and long-term healthcare goals;

g. Name of patient's provider; and

h. PCMH contact Information.

3. Evidence exists, in QI Meeting minutes, that the organization:

PATIENT CENTERED MEDICAL HOME

a. Audits patient health records for completeness and accuracy. Audit results meet compliance with the number of records and frequency, as defined by organizational policy;

b. Analyzes data and reports findings to leadership; and

c. Identifies performance improvement opportunities and takes corrective action.

QUALITY IMPROVEMENT PLAN

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

EVIDENCE OF COMPLIANCE

Patient Satisfaction Survey

1. The organization ensures a sample of patients receive a patient satisfaction survey. The patient sample size is determined by organizational policy.
2. The results of the patient satisfaction surveys are collected, evaluated and presented at QI/staff meetings. Results are submitted to a national database for outcomes measurement.
3. The organization has a process to develop and implement corrective action if the results of the patient satisfaction evaluation reveal possible issues.

Complaints

4. The organization has a written policy and procedure for defining, handling, reviewing and resolving complaints.
5. The organization provides its patients with written information on the complaint process, which includes the statement " In the event your complaint remains unsolved with <organization name>, you may file a complaint with our accreditor, The Compliance Team, Inc. via their website (www.thecomplianceteam.org) or via phone 1-888-291-5353."
6. When a complaint is received, the organization provides notice to the complainant that the issue is being investigated within the timeframe identified in the organization policy.

QUALITY IMPROVEMENT PLAN

QI 2.0	**The organization performs an annual evaluation of its written policies and procedures for continuous quality improvement. Findings are evaluated to ensure it is following the guiding principles of the Patient-Centered Medical Home Model.**

EVIDENCE OF COMPLIANCE

1. The organization has written policies and procedures outlining its Quality Improvement (QI) activities. The policies and procedures include the following:

   a. Designating a staff member for oversight of the QI activities.

   b. Monitoring the following:

      i. Completeness/accuracy of patient health records (random chart audit volume and frequency will be determined by organizational policy);

      ii. Compliance with preventive-health measures (as required by Medicaid or third-party payers);

      iii. Compliance with the continuity of care process (which addresses the coordination of care regarding patient appointments and provider orders/labs/diagnostics/referrals) that close the gaps in patient care transitions;

      iv. Incident reporting;

      v. Patient satisfaction data;

      vi. Number of same day appointments (which addresses increased patient access);

      vii. Number of patients being identified as high-risk and/or complex, for which the PCMH is pro-actively managing. "High-risk and/or complex" is defined by organizational policy.

      viii. Percentage of generic medications prescribed; and

      ix. Number of emergency department visits by high-risk and/or complex patients who visit the emergency department frequently. “Frequently” is defined by organizational policy clarifying the number of visits within a timeframe.

QUALITY IMPROVEMENT PLAN

x. Number of patients followed-up after discharge from the hospital (as determined by Admission/Discharge/Transfer reporting).

c. Analyzing data and reviewing findings with key leadership at least quarterly.

d. Identifying performance improvement opportunities and taking corrective action when needed.

e. Communicating changes throughout the organization.

f. Following-up to ensure the desired change is achieved through the corrective action(s).

2. Annually, the organization performs a program evaluation to:

a. Review the following:

i. Utilization review of all services provided by the PCMH;

ii. The number of patients served and volume of services;

iii. Organizational policies and procedures; and

iv. Trends from the past year's QI data (as defined in QI 2.0.1(b)(i-x).

b. Determine whether the PCMH plan supports compliance with the guiding principles of PCMH which includes improved patient access, team-based care approach, care coordination, utilization of the PCHIP™, and patient follow-up. The organization creates and uses a simple self-assessment checklist for this purpose.

c. Make changes to the PCMH plan as required.

3. Evidence exists of the QI data collection and analysis, findings, action-plans, follow-up, and the annual PCMH program evaluation.

PLEASE NOTE: IF YOU ARE A TCT ACCREDITED RURAL HEALTH CLINIC- THE STANDARDS BEYOND THIS POINT DO NOT APPLY TO YOU.

PLEASE NOTE: ORGANIZATIONS THAT ARE NOT AN ACCREDITED TCT RURAL HEALTH CLINIC MUST MEET THE ADDITIONAL STANDARDS OUTLINED IN THE FOLLOWING PAGES.

CORPORATE COMPLIANCE

COM 1.0 The organization has a Corporate Compliance plan.

EVIDENCE OF COMPLIANCE

1. The organization has written policies and procedures required for an effective compliance program that include the following:
    a. Designating a Compliance Officer;
    b. Having written Standards of Conduct that include a non-retaliation statement;
    c. Following procedures to prevent, detect, and correct Fraud, Waste, and Abuse;
    d. Performing a Risk Assessment that addresses areas of vulnerability;
    e. Utilizing continuous Quality Improvement techniques (e.g. auditing, problem identification, investigation, and corrective action); and
    f. Following disciplinary and corrective action plans when non-compliance is suspected.
2. Evidence exists that staff has been trained on all elements of the Corporate Compliance Plan upon-hire and annually. When interviewed, staff is knowledgeable of the Standards of Conduct for the organization.

COM 2.0 The organization is in good standing with Medicare/Medicaid programs.

EVIDENCE OF COMPLIANCE

1. The organization, which participates in the Medicare/Medicaid program, has been free of sanctions for a period of at least 2 years.
2. The organization takes steps at on-boarding (and annually) to prohibit the employment or contracting of individuals or companies that have been convicted of a criminal felony offense related to healthcare.
    a. There is evidence of verification of individuals through the OIG exclusion database, www.oig.hhs.gov.

CORPORATE COMPLIANCE

COM 3.0 The organization's staff are licensed, certified, or registered in accordance with applicable State laws.

EVIDENCE OF COMPLIANCE

1. The organization has a written process verifying applicable personnel are licensed, certified, or registered, as required by State law.
2. This information is documented and tracked in an organized format.

ADMINISTRATRATION

ADM 1.0 The organization has a governing body or individual having legal responsibility for the conduct of the organization.

EVIDENCE OF COMPLIANCE

1. The organization has proof of ownership.
2. The organization reports any change in ownership to The Compliance Team.
3. The organization has an organizational chart.
4. The organization has a protocol that identifies who is in charge of day-to-day operations in the absence of key leadership.

ADM 2.0 The organization follows written policies and procedures for the maintenance of patient health records.

EVIDENCE OF COMPLIANCE

1. The organization has written policies and procedures to ensure patient health records are maintained in accordance with policy. The policies include:
    a. Having a patient health record for every person receiving services by the organization.
    b. Designating a member of the organization's professional staff who is responsible for the maintenance of patient health records by ensuring they are:
        i. Complete and accurately documented.
        ii. Readily accessible and systematically organized.
        iii. Complete when patients are referred or transferred.

ADMINISTRATRATION

ADM 3.0 The organization follows written policies and procedures addressing protected health information.

EVIDENCE OF COMPLIANCE

1. The organization has written policies and procedures addressing protected health information (PHI) that address the use, security, and removal of patient health records as required by current HIPAA regulations. The policies and procedures include:
   a. Describing the steps taken by staff to ensure a patient's privacy during the provision of service and on-going confidentiality is maintained;
   b. Ensuring safeguards are in place to protect health information against loss, destruction, and unauthorized use;
   c. Publicly posting a privacy notice and making it available to all patients at time of initial contact;
   d. Requiring a patient's consent for the release of PHI before any information not authorized by law is released;
   e. Ensuring Business Associate Agreements (BAA) are in place when an entity or contractor, having access to PHI, is engaged by the organization; and
   f. Maintaining patient health records, at a minimum, 6 years from the last date of entry or longer if required by State statute.
2. Evidence exists that all staff is trained on patient privacy, confidentiality, and HIPAA regulations upon-hire and annually.

HUMAN RESOURCES

HR 1.0 The organization follows written policies and procedures for hiring, orienting, and training all staff.

EVIDENCE OF COMPLIANCE

1. The organization has written policies and procedures for human resources that are consistent with the needs for the services it provides to its beneficiaries. The policies include:
   a. Specifying personnel qualifications and experience requirements.
   b. Specifying training, competency, and continuing education requirements.
2. Evidence exists of staff training and validation of competency upon hire, annually, when new services are added, or when a staff member's performance warrants it.

HR 2.0 The organization has written job descriptions for all staff.

EVIDENCE OF COMPLIANCE

1. The organization has written job descriptions (or checklists) outlining all staff members' responsibilities and accountabilities.
2. Evidence exists that staff members' job descriptions are signed, dated, and placed in their personnel file.

HUMAN RESOURCES

HR 3.0 The organization maintains personnel files on all employees and independent contractors.

EVIDENCE OF COMPLIANCE

1. The organization's confidential personnel files contain the following:
   a. W-4, I-9 for employees;
   b. Curriculum Vitae, Application or Resume with references;
   c. Signed Job Description or contractual agreement;
   d. Orientation/Training /Competency Assessment checklists;
   e. Signed Standards of Conduct;
   f. Copy and validation of current (and past) professional license, registration and/or certification, as applicable;
   g. OIG exclusion list verification;
   h. Annual performance evaluations;
   i. Background checks (when required by the State or organizational policy);
   j. Hepatitis B vaccine record or declination. These items are maintained in a separate and secure employee health file;
   k. TB evaluation requirements (for staff members with patient contact, specific to the job description). These items are maintained in a separate and secure employee health file; and
   l. Copy of current Basic Life Support certification for all licensed personnel providing patient care. This includes a higher-level certification (e.g., ACLS, PALS) when required by organizational policy.

RISK MANAGEMENT

RSK 1.0 The organization has a written process for receiving, reviewing, and preventing patient incidents.

EVIDENCE OF COMPLIANCE

1. The organization has evidence that incidents are documented on a specific form. The organization can provide a copy of this form upon request.
2. There is a designated staff member responsible for reviewing all incidents and a process in place for taking corrective action and following-up. If the incident results in hospitalization or death, it is reported to TCT within 48 hours.
3. Evidence exists that employees have been trained and are knowledgeable of the process.

RSK 2.0 The organization has a written process for handling employee injuries or exposures.

EVIDENCE OF COMPLIANCE

1. The organization has evidence that employee incidents, injuries or exposures are documented on a specific form.
2. There is a designated staff member responsible for reviewing all incidents and a process in place for taking corrective action and following-up. If the incident results in hospitalization or death, it is reported to TCT within 48 hours.
3. Employee incidents, injuries or exposure are documented on an incident form.
4. Evidence exists that employees have been trained and are knowledgeable of the process.

EQUIPMENT MANAGEMENT

EQP 1.0 The organization follows written policies and procedures for equipment management.

EVIDENCE OF COMPLIANCE

1. The organization's equipment management policies and procedures clearly state the process for cleaning, maintaining and storing all equipment. Policies include the following requirements:
   a. All equipment, including equipment loaned to patients (e.g., crutches, wheelchairs or walkers), is cleaned with a healthcare disinfectant according to manufacturer's directions and kept sanitary prior to each patient's use.
   b. Equipment/supplies are stored on shelves, in cabinets and off the floor.
   c. Defective and obsolete equipment is appropriately labeled.
2. The organization's equipment management policies and procedures address specialty compliance concerning the storage of oxygen tank as applicable:
   a. All oxygen tanks are properly secured and maintained in a well-ventilated area.
   b. If multiple oxygen tanks are maintained, full tanks are stored separately from those that are empty or partially full.
3. The organization has written policies and procedures describing a preventive maintenance program to ensure that:
   a. All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition.
      i. Equipment is inspected/tested according to manufacturer's guidelines and assessed prior to patient use to ensure it is in working order.
      ii. Evidence exists of all preventive maintenance or repairs.

INFECTION CONTROL

INF 1.0 The organization follows infection prevention techniques that relate to the type of patient served, services provided and the staff's risk for exposure.

EVIDENCE OF COMPLIANCE

1. The organization has a written infection control policy and procedure reviewed annually.
2. The organization practices infection prevention techniques by utilizing the following:
   a. Hand washing or use of alcohol-based gel before and after each patient contact.
   b. Utilization of gloves while handling or cleaning dirty equipment.
   c. Proper disposal of gloves, sharps and other waste throughout the practice including red bag use.
   d. Standard Precautions when at risk for exposure to blood-borne pathogens.
   e. Prevents cross-contamination by segregating clean from dirty in utility and or storage areas.
3. All sterilization equipment and procedures follow manufacturer guidelines for use.
   a. All instruments are cleaned and sterilized according to the manufacturer's instructions for use.
   b. All sterile packaging has an identifiable expiration due date (if required by manufacturer guidelines).
4. The organization's personnel receive education and training on infection control annually.

PATIENT SERVICES

PTS 1.0 The organization has a process to protect the patient's rights and responsibilities.

EVIDENCE OF COMPLIANCE

1. The organization has a written patient rights and responsibilities document which is posted and available to patients upon request.
2. Evidence exists that staff has been trained and are knowledgeable on the patient rights and responsibilities document.

PTS 2.0 The organization provides written information to all patients, or when appropriate, the patient's representative, as allowed by State law, upon admission to services.

EVIDENCE OF COMPLIANCE

1. The organization has a process that information given to patients (or when appropriate, the patient's representative as allowed by State law) contains individual rights under State law to make decisions concerning medical care which includes:
   a. Attaining written consent to treat.
   b. Accepting or refusing care.
   c. Determining the relationship of an authorized representative for all minors and adult patients not capable of giving their consent.

PHARMACEUTICAL SERVICES

DRG 1.0 The organization has written policies and procedures for the storage, handling, and dispensing of drugs and biologicals.

EVIDENCE OF COMPLIANCE

1. The organization's written policies and procedures include:

    a. Requirements that drugs are stored in original manufacturer's containers to maintain proper labeling.

    b. Requirements that multiple dose vials and single dose vials are stored according to manufacturer guidelines.

    c. Requirements that drugs and biologicals dispensed to patients have complete and legible labeling of containers;

    d. Requirements for a process to regularly monitor the inventory of the organization's drugs, biologicals, and supplies for expiration by the manufacturer's date, beyond-use-dating, or evidence of recall.

    e. Requirements for a process to handle outdated, deteriorated, or adulterated drugs, biologicals, and supplies. These are stored separately and the disposal is in compliance with applicable State laws.

    f. Requirements for storage in a space that provides proper humidity, temperature, and light to maintain quality of drugs and biologicals that includes the following:

        i. Refrigerated or frozen medication or vaccines are monitored for storage temperature at least twice daily.

        ii. Temperatures are recorded in a log and staff reports variances in normal findings to organizational leadership.

        iii. No drugs or biologicals are stored in the door of the refrigerator or freezer.

        iv. Water bottles are placed in the door of the medication refrigerator to promote temperature stability.

PHARMACEUTICAL SERVICES

g. Requirements that current drugs references, antidote information, and manufacturer's guidelines are available on the premises.

h. All controlled substances are handled, as directed by the Drug Enforcement Agency (DEA) Practitioner's Manual, in a manner that guards against theft and diversion.

    i. Schedule II drugs are stored in a securely constructed locked compartment, separate from other drugs.

    ii. Schedule III, IV, and V drugs are secured in a substantially constructed cabinet.

    iii. The organization maintains adequate record keeping of the receipt of controlled drugs and a reconcilable log of the distribution. Should Schedule II drugs be administered in the organization, these drugs are accounted for separately. Any thefts or significant losses are reported to the DEA.

i. Requirements that containers used to dispense drugs and biologicals to patients conform to the Poison Prevention Packaging Act of 1970;

j. Requirements that all prescribing and dispensing of drugs shall be in compliance with applicable State laws.

k. Drugs, Biologicals, and Supplies are appropriately stored.

    i. All sharps, chemicals and electrical hazards are secured.

DIAGNOSTIC SERVICES

DGS 1.0 The organization provides basic laboratory services essential to immediate diagnosis and treatment as applicable.

EVIDENCE OF COMPLIANCE

1. The organization has an appropriate CLIA.
2. Evidence exists that all staff performing lab services have been trained and their competency validated upon-hire and annually.

REGULATORY

REG 1.0 The organization is in compliance with applicable local, State, and Federal laws or regulations.

EVIDENCE OF COMPLIANCE

1. The organization is licensed in accordance with applicable State and local laws.
2. The organization displays all licenses, certificates and permits to operate, as required.

REG 2.A The organization is in compliance with the OSHA Blood-Borne Pathogen Standard as it relates to the type of patient served, services provided, and staff's risk for exposure.

EVIDENCE OF COMPLIANCE

1. The organization has a written work-exposure plan that determines the job classifications of staff at risk of blood-borne pathogen exposure and the work-practice controls and personal protective equipment (PPE) that are made available to protect them. The plan is reviewed and/or updated at least annually.
2. All PPE is provided by the employer and is readily accessible to staff.
3. If identified as being at risk for exposure to blood-borne pathogens, the staff member is offered full Hepatitis B vaccination series at the employer's expense. If declined, a signed declination form appears in the personnel file.
4. Evidence exists that all staff have received training on the OSHA Bloodborne Pathogens Standard upon-hire and annually.

REGULATORY

REG 2.B The organization is in compliance with current OSHA and CDC guidelines for preventing the transmission of Mycobacterium Tuberculosis in health care settings.

EVIDENCE OF COMPLIANCE

1. The organization conducts an initial and on-going risk assessment for TB transmission by occupational exposure. Factors to be considered may include: risk by geographical location as determined by the State Department of Health, the type of patient population served (including fluctuations of population caused by temporary workers or tourism), and the reported cases of TB in the organization in the past year.
2. Based upon assessment of risk, the organization follows current OSHA and CDC guidelines to determine the types of administrative, environmental, respiratory protection controls, and medical surveillance needed.
3. There is evidence the organization conducts TB screening upon hire.
4. Evidence exists that all staff have received TB transmission prevention training upon-hire and annually.

REG 2.C The organization is in compliance with OSHA's Right to Know Standard.

EVIDENCE OF COMPLIANCE

1. Safety Data Sheets (SDS) are available for all hazardous material in the organization's workplace and employees are knowledgeable of the location of the references.
2. The organization posts all mandatory OSHA posters for all employees to view.
3. Evidence exists that staff is trained on identifying hazards in the workplace.

REGULATORY

REG 2.D The organization has an emergency preparedness plan that addresses an emergency on-site, off-site (natural disaster) and disruption of service.

EVIDENCE OF COMPLIANCE

1. The organization has a written emergency preparedness plan with an organized process for handling an on-site emergency, (e.g., fire, active shooter) addressing the following:
   a. How employees will be notified of emergency;
   b. Which staff member is responsible for calling 911;
   c. The location where employees should meet outside the building; and
   d. The staff person designated to do head count upon evacuation of the building
2. Fire Safety requirements are met as follows:
   a. Fire extinguisher is mounted and has been checked and approved for use.
   b. Upon on hire and annual in-service for all employees on Fire Safety (including how to operate an extinguisher).
3. The organization has a written emergency preparedness plan with an organized process for handling an off-site emergency, (e.g. snowstorm, flood, etc.) addressing the following:
   a. How employees will be notified of emergency;
   b. Which staff member is responsible for notification of patients;
   c. How refrigerated medications are handled during a power outage; and
   d. How it will implement a contingency plan, that includes routing patients to an alternative provider in the event the organization cannot see its own patients for an extended period of time.