<<Practice Name>>

Patient Centered Healthcare Home
Program Description

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a.

I. Organizational Overview

<<Practice Name>> is dedicated to providing the highest quality services to all they serve and fulfill their mission, "<<mission statement>>." [PO 2(a)] <<Practice Name>> holds an active healthcare practice license in the state of <<state>> and is legally organized in accordance with state law. <<Practice Name>> has <<Brief overview of the number and types of offices and locations, # and types of staff employed, payer contracts, etc… >>. <<Practice Name>> is an active participant in its community which provides healthcare services to ….<<Brief description of the practices' population served- including # in surrounding population, # of enrolled patients, regional/community make-up, general population statistics (age, gender, chronic conditions), etc…>>. [PO 2(c)]

a.PCHCH Program Framework [PO 2(b)]

A Patient Centered Health Care Home (PCHCH) is a quality driven, interdisciplinary clinician led team approach to delivering and coordinating care that puts patients, family members, and personal caregivers at the center of all decisions concerning the patient's health and wellness. A PCHCH provides comprehensive and individualized access to physical health, behavioral health, and supportive community and social services, ensuring patients receive the right care in the right setting at the right time. The scope and content of the <<Practice Name>> PCHCH Program embraces this definition and is designed to integrate family, caregivers, patients, and care coordination in the delivery of quality health care to patients. The PCHCH seeks to optimize value for its patients, payers, and society at large, driven by a commitment to care excellence and customer service. <<Practice Name>> establishes a team based care delivery structure, with the team sharing responsibility for promoting the overall health, function, and well-being of the patient. This PCHCH framework is accomplished through a patient-centered approach which includes the following 7 components which are essential to primary healthcare:

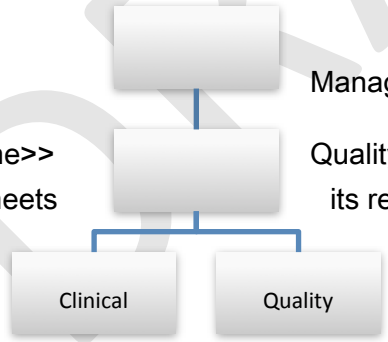
1. Core Quality Management
2. Quality Performance Reporting and Improvement
3. Patient-Centered Operations Management
4. Access and Communications
5. Testing and Referrals

6. Care Management and Coordination

7. Electronic Capabilities

b.Oversight and Authority [PO 2(d)]

The <<Practice Name>> Board of Directors has ultimate authority over the governance of the organization and its programs as depicted in the below framework. The <<Practice Name>> BOD provides oversight to the organization through the review of routine reports and quarterly committee. The Board of Directors delegates this authority to the Leadership Committee, but is provided with a report of the QM program and evaluation of its activities at least annually. Each <<Practice Name>> leader/manager is delegated day to day operational management. The day-to-day operation of the PCHCH Program is overseen by the Senior Clinical Staff Person, who is a board certified M.D. or D.O. Organizational committee membership includes selected representatives from each area of the organization. This inclusion of representation from the various departments allows for collaboration, coordination and communication among disciplines and departments within the organization. This helps to promote integration of administrative activities, quality improvement, and clinical operations across the organization.

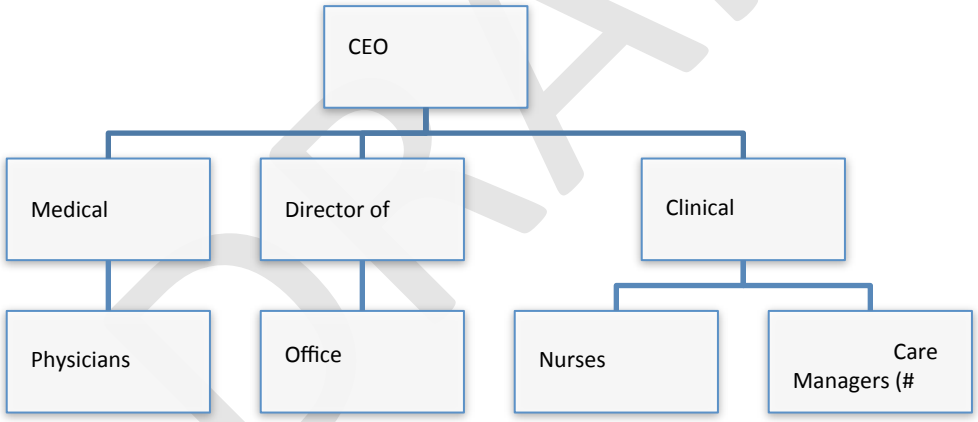


II. Core Quality Management

The <<Practice Name>> Quality Management program helps to ensure <<Organization>> meets its responsibilities to its contractors, patients, and the community through continuous and systematic assessment and improvement of program services, processes, and outcomes. The Quality Management Program is the vehicle through which the <<Practice Name>> analyzes and responds to data collected by its medical record system, claims data, operational performance monitoring, and other program measurement processes. The purpose of the Quality Management program is to systematically use performance information and data to improve clinical care, staff training, services, and ultimately patient outcomes.

a. Staff Management

To further promote Quality Management, <<Practice Name>> seeks to provide a rewarding place to work, offering a high level of job training and satisfaction for all members of the team allowing team members to optimize their training and experience. <<Practice Name>> provides and tracks staff orientation and ongoing training to ensure staff have the skills and education necessary to perform their roles. Additionally, <<Practice Name>> develops job descriptions for each role and has mechanisms to ensure appropriately qualified and licensed staff is employed in each role. <<Practice Name>> evaluates staff performance through on-going monitoring and provides formal feedback to staff at least annually. As outlined in the below organizational chart, the Practice has a clearly defined organizational structure outlining direct and indirect oversight responsibility throughout the organization which provides optimal oversight and ability for staff to access supervision when needed.



<<Practice Name>> also identifies a designated staff to promote three critical functions in the organization: [PO 1]

- Teamwork Facilitator- this staff is responsible for promoting a positive work environment and building teamwork.
- Clinical Facilitator- this staff is responsible for monitoring clinical operations, including order tracking, and transitions of care.
- QI Facilitator- this staff is responsible for the coordination and tracking of all continuous quality improvement activities.

b. Performance Monitoring

The Quality Management Committee (QMC) who is granted authority by the <<Practice Name>> Board of Directors is responsible for the management of the Quality program. This committee meets at least quarterly with the purpose of improving services by monitoring processes, implementing interventions to improve, and evaluating the effectiveness of those interventions. The QMC is responsible for the following activities:

- Review and approval of practice policies and protocols
- Review and analysis of the key performance indicators listed below
- Guidance for QM priorities and projects
- Identification and development of action plans to improve or correct identified problems or meet acceptable levels of performance

The QMC routinely monitors the following key performance indicators:

- Regulatory compliance, including HIPAA and URAC accreditation
- Accessibility and Availability of program services and staff
- Patient Visit Data
- Tracking of Tests and specialty Referrals
- Wellness & Health Prevention program outcomes
- Medication Review and Reconciliation Reports
- Patient Registry Accuracy Reports
- Staff and Patient/Family/Caregiver satisfaction regarding the PCHCH program
- Monitoring, evaluating and resolution of Consumer complaints

- Staff's performance and adherence to policies and procedures
- Appropriate credentialing of Licensed Staff
- Tracking and follow-up processes for Adverse Incidents to ensure Consumer safety
- Chronic Conditions and Gaps in Care Report

III. Performance Reporting and Improvement

<<Practice Name>> utilizes performance feedback to enable clinicians to decrease gaps in care and improve patient outcomes. <<Practice Name>> implements reporting technology that allows clinicians to generate point-of-care reports, population-level reports, and trend analyses to identify opportunities for improving care delivered to patients.

IV. Patient Centered Operations

The PCHCH program has a primary focus to ensure all services and supports are provided with a patient-centered focus. <<Practice Name>> establishes a PCHCH program to optimally manage a population of patients, improve health status, and ultimately lower health care costs. <<Practice Name>> utilizes a Patient Registry to manage the PCHCH program and to identify care gaps and needed preventive, wellness, and follow-up services.

V. Access and Communications

Through its PCHCH program <<Practice Name>> seeks to empower patients and their families/caregivers to be active participants in their care, through patient-friendly education and informed shared decision-making that is based on cooperation, trust, and respect for each individual's health care knowledge and health literacy, values, beliefs, and cultural background. <<Practice Name>> also seeks to ensure all patients have comprehensive and timely access to health care services that are patient centered, culturally sensitive, and delivered in the least intensive and most appropriate setting

based on the patient's needs. This includes helping patients connect with needed community services and resources by implementing processes that coordinate care between the PCHCH, community services agencies, family, caregivers, and the patient.

VI. Testing and Referrals

<<Practice Name>> PCHCH program implements a standardized, reliable system to ensure patients receive needed tests and imaging that results are communicated in a timely manner, appropriate follow-up care is conducted, and each step in the testing and imaging tracking process is properly document. Additionally, well-coordinated process where PCHCH patients are referred to specialty care in an efficient manner, and both the practice clinicians and specialists receive timely access to the information they need to provide optimal care to the patient.

VII. Wellness and Health Promotion

<<Practice Name>>'s PCHCH program promotes improved health through wellness and preventive services component which uses health screening, active counseling, and outreach efforts to inform and educate patients about the value of preventive care. The wellness and health promotion program utilizes population-based tools to support and monitor wellness and care goals for each patient, aimed at preventing illness and improving individual well-being, clinical outcomes and quality of life.

VIII. Care Management and Coordination

An essential component of the PCHCH program is to ensure patients with chronic conditions receive organized, planned care from a team of multi-disciplinary clinicians, and that patients are empowered to take greater responsibility for their health, leading to improved health status and decreased health care costs. <<Practice Name>> seeks to improve patient care by implementing processes that will help clinicians coordinate treatment, communicate with one another, manage health care setting transitions, communicate care options to the patients, and track patient activity. <<Practice Name>>'s PCHCH is a comprehensive program that uses patient education tools, informative sessions, and life skills training to offer support to chronic care patients, and to help them to manage their condition. This program is accountable for coordinating, providing, and monitoring a patient's needs, medical and behavioral health treatment, care transitions, and social and community services through the creation of an appropriate individual plan of care.

IX. Electronic Capabilities

A critical component to the sustainability and efficiency of the PCHCH program is the use of advanced electronic capabilities. <<Practice Name>> has an Electronic Health Record which integrates patient information from all care sources, within and outside the practice. <<Practice Name>> implements a patient portal system that allows clinicians to manage and interact with their patients online. Utilizing this system, patients are able to access their health records online, and the clinicians are able to send reminders and health care literature, and conduct e-visits. Additionally, <<Practice Name>> utilizes an automated prescribing and medication reconciliation process, providing alerts for medication and allergy conflicts, therapeutic equivalent and generic substitution information, streamlining prescription fills and renewals, and providing clinicians with patient-specific coverage and insurance formulary information.