**PCMH 2018 Links**

2.1

Reference AAFP article for additional information on creating a registry:    http://www.aafp.org/fpm/2011/0500/p11.html

4.1

Reference information provided at the Improving Chronic Illness Care website:   <http://www.improvingchroniccare.org>

4.4

Reference information at Agency for Healthcare Research and Quality about CAHPS:   http://www.ahrq.gov/cahps/index.html

4.4.iii

Reference information at Agency for Healthcare Research and Quality about CAHPS:  http://www.ahrq.gov/cahps/index.html

4.5

Reference information provided at the Improving Chronic Illness Care website:   http://www.improvingchroniccare.org/index.php?p=self‐management\_support&s=39

4.9

Reference information provided at the Improving Chronic Illness Care website:   http://www.improvingchroniccare.org/index.php?p=self‐management\_support&s=39

4.15

Reference AAFP information on group visits at:  <http://www.aafp.org/fpm/20060100/37grou.html>

4.17

Information about survivorship plans can be accessed at:  http://www.cancer.org/Treatment/SurvivorshipDuringandAfterTreatment/Survivors hipCarePlans/index

4.18 e

Reference http://www.nationalconsensusproject.org/Guidelines\_Download2.aspx for  definition of palliative care, and an overview of the domains that should be addressed in the  delivery of comprehensive palliative care

1. Advance care planning:  www.prepareforyourcare.org (available in multiple languages);
2. www.makingyourwishesknown.com; State of Michigan advance  directive documents available at: iii
3. http://www.mibluecrosscomplete.com/resources/advance‐directive.html   Spiritual distress:
4. https://www.hpsm.org/documents/End\_of\_Life\_Summit\_FICA\_References.pdf   iii. Prognosis:  http://eprognosis.ucsf.edu/  iv. Hospice eligibility:  http://geriatrics.uthscsa.edu/tools/Hospice\_elegibility\_card\_\_Ross\_and\_Sanchez\_R eilly\_2008.pdf;

4.18 g

Palliative Care Nursing Certification for APRNs, RNs, LPNs, CNAs:

c. http://hpcc.advancingexpertcare.org/competence/certifications‐offered/

Palliative Care Social Work Certification:

d. http://www.socialworkers.org/credentials/credentials/achp.asp

e. Professional Chaplaincy Certification:  http://bcci.professionalchaplains.org/content.asp?admin=Y&pl=42&sl=42&c ontentid=45

f. Education in Palliative and End of Life Care:  www.epec.net  – all health care

5.7 h

http://www.aafp.org/fpm/20000900/45same.html

ii. http://www.managedcaremag.com/archives/2002/12/same-day-appointmentspromise-increased-productivity

iii. Reference Institute for Healthcare Improvement articles at  http://www.ihi.org/Topics/PrimaryCareAccess/Pages/default.aspx for information  on implementing advanced access

8.10

Reference for sample forms  http://www.naddi.org/aws/NADDI/asset\_manager/get\_file/32898/opioidagreemen ts.pdf

9.2

Preventive care guidelines are integrated into clinical practice (e.g., Michigan Quality  Improvement Consortium ‐ [www.mqic.org](http://www.mqic.org)).

11.2

IHI Partnering in Self‐Management Support:  A Toolkit for Clinicians

http://www.ihi.org/knowledge/Pages/Tools/SelfManagementToolki tforClinicians.aspx

Self‐Management Support Information for Patients and Families:   http://www.ihi.org/resources/Pages/Tools/SelfManagementToolkitforPatientsF amilies.aspx

California Health Care Foundation Self‐Management

http://www.chcf.org/publications/2009/09/selfmanagementsupport‐training‐materials

Flinders Self‐Management Model:  http://www.flinders.edu.au/medicine/fms/sites/FHBHRU/documents/publi cautions/FLINDERS%20PROGRAM%20INFORMATION%20PAPER%20FINAL\_M. pdf

Motivational Interviewing

<http://www.motivationalinterviewing.org/>

12.6

The guidelines are available here:

<http://www.aafp.org/online/en/home/policy/policies/e/evisits.html>

Documents Section:

IG 2018 Number Type of Change:

1.1 Required

Practice unit has developed PCMH‐related patient communication tools, has trained staff,  and is prepared to implement patient‐provider partnership with each current patient, which  may consist of a signed agreement or other documented patient communication process to  establish patient‐provider partnership

4.6 Required

A systematic approach is in place for appointment tracking and generation of reminders for  the patient population selected for initial focus

5.1 Required

Patients have 24‐hour access to a clinical decision‐maker by phone, and clinical decisionmaker has a feedback loop within 24 hours or next business day to the patient's PCMH

6.2 Required

Systematic approach and identified timeframes are in place for ensuring patients receive  needed tests and practice obtains results

6.5 Required

Systematic approach is used to inform patients about all abnormal test results

10.2 Required

PO maintains a community resource database based on input from Practice Units that serves  as a central repository of information for all Practice Units

IG 2018 Number Type of Change:

1.9 Retired

Providers ensure that patients are aware that as part of comprehensive, quality care and to  support population management, health care information is shared among care partners as  necessary.

2.5 Retired

Registry contains information on the individual practitioner for every patient currently in the  registry who is an established patient in the practice unit

6.3 Retired

Process is in place for ensuring patient contact details are kept up to date

12.1 Retired

Assessment of vendor options may be conducted by PO or Practice Unit.

12.2 Retired

PO or Practice Unit has assessed liability and safety issues involved in maintaining a patient  web portal at any level and developed policies that allow for a safe and efficient exchange of  information

14.5 Retired

Practice Unit or designee ensures patients are scheduled for specialist appointments in timely  manner