

PCMH Standards

Planetree Designation Criteria

PCMH 1: Patient-Centered Access - The practice provides access to team-based care for both routine and urgent needs of patients/families/caregivers at all times.

Element A: Patient-Centered Access. The practice has a written process and defined standards for providing access to appointments, and regularly assesses its performance on:

1. Providing same-day appointments for routine and urgent care. (CRITICAL FACTOR)
2. Providing routine and urgent-care appointments outside regular business hours.
3. Providing alternative types of clinical encounters.
4. Availability of appointments.
5. Monitoring no-show rates.
6. Acting on identified opportunities to improve access.

Element B: 24/7 Access to Clinical Advice. The practice has a written process and defined standards for providing access to clinical advice and continuity of medical record information at all times, and regularly assesses its performance on:

1. Providing continuity of medical record information for care and advice when office is closed.
2. Providing timely clinical advice by telephone. (CRITICAL FACTOR)
3. Providing timely clinical advice using a secure, interactive electronic system.
4. Documenting clinical advice in patient records.

III.A–Acute Care and Continuing Care Application: A policy for sharing clinical information, including the medical record and the care plan, with patients/residents has been approved, staff are educated on this policy and the process for sharing the record and care plan, an effective system is in place to make patients/residents aware that they may review this information, and a process is in place to facilitate patients/residents documenting their comments.

III.A-Behavioral Health Application: In behavioral health settings, decisions about the extent of the clinical information shared and the mechanism used for sharing this information are made on an individualized basis. A range of options are available for sharing such information, including the medical record and the treatment plan, to ensure that patients of varying competency levels have access to information that will help them to understand their symptoms, diagnosis and treatment.

III.D: The site has a process to assist patients/residents and families in managing their medical information and coordinating their care among multiple physicians, including their admitting physician, primary care provider and appropriate specialists. An example is providing patient access to personal health information via the organization’s electronic patient portal.

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Element C: Electronic Access. The following information and services are provided to patients/families/ caregivers, as specified, through a secure electronic system.

1. More than 50 percent of patients have online access to their health information within four business days of when the information is available to the practice.
2. More than 5 percent of patients view, and are provided the capability to download, their health information or transmit their health information to a third party.
3. Clinical summaries are provided within 1 business day for more than 50 percent of office visits.
4. A secure message was sent to more than 5 percent of patients.
5. Patients have two-way communication with the practice.
6. Patients can request appointments, prescription refills, referrals and test results.

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III.A–Acute Care and Continuing Care Application: A policy for sharing clinical information, including the medical record and the care plan, with patients/residents has been approved, staff are educated on this policy and the process for sharing the record and care plan, an effective system is in place to make patients/residents aware that they may review this information, and a process is in place to facilitate patients/residents documenting their comments.

III.C: Patients/residents are provided with meaningful discharge/transition instructions in a manner that accommodates their level of understanding and in a language that they understand.

III.D: The site has a process to assist patients/residents and families in managing their medical information and coordinating their care among multiple physicians, including their admitting physician, primary care provider and appropriate specialists. An example is providing patient access to personal health information via the organization’s electronic patient portal.

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PCMH 2: Team-Based Care - The practice provides continuity of care using culturally and linguistically appropriate, team-based approaches.

Element A: Continuity. The practice provides continuity of care for patients/families by:

1. Assisting patients/families to select a personal clinician and documenting the selection in practice records.
2. Monitoring the percentage of patient visits with selected clinician or team.
3. Having a process to orient new patients to the practice.
4. Collaborating with the patient/family to develop/implement a written care plan for transitioning from pediatric care to adult care.

X.C: The organization works with other local healthcare providers across the continuum of care to improve care coordination, communication and information exchanges around the needs of each patient/resident and family, especially during transitions of care.

II.P: Staff engages patients/residents, family and/or their advocates in the care planning process. Examples may include use of shared decision making tools, health coaching and collaborative care conferences.

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Element B: Medical Home Responsibilities. The practice has a process for informing patients/families about the role of the medical home and gives patients/families materials that contain the following information:

1. The practice is responsible for coordinating patient care across multiple settings.
2. Instructions for obtaining care and clinical advice during office hours and when the office is closed.
3. The practice functions most effectively as a medical home if patients provide a complete medical history and information about care obtained outside the practice.
4. The care team provides access to evidence-based care, patient/family education and self-management support.
5. The scope of services available within the practice including how behavioral health needs are addressed.
6. The practice provides equal access to all of their patients regardless of source of payment.
7. The practice gives uninsured patients information about obtaining coverage.
8. Instructions on transferring records to the practice, including a point of contact at the practice.

Element C: Culturally and Linguistically Appropriate Services. The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by:

1. Assessing the diversity of its population.
2. Assessing the language needs of its population.
3. Providing interpretation or bilingual services to meet the language needs of its population.
4. Providing printed materials in the languages of its population.

III.C: Patients/residents are provided with meaningful discharge/transition instructions in a manner that accommodates their level of understanding and in a language that they understand.

X.C: The organization works with other local healthcare providers across the continuum of care to improve care coordination, communication and information exchanges around the needs of each patient/resident and family, especially during transitions of care.

IX.C: Patients'/residents' health and wellness needs are approached holistically and in consideration of the person's expressed health goals and priorities. Caregivers assess the ability of each patient/resident and family member to self-manage their health care needs, and support is available, as needed, to enhance self-management abilities. Examples include home monitoring, health coach support, programs that support patients/residents/family in chronic disease management, stress management, nutrition, etc.

II.L: Processes are in place to help patients/residents anticipate the costs of care and assistance is available for those who need to make financial arrangements. Financial communications are concise, clear and respectful.

VIII.B: Accommodations are made to integrate individual patients'/residents' cultural norms, needs and beliefs into their care and treatment plan upon request. III.B: A range of educational materials, including consumer health, those designed to accommodate a range of health literacy levels and culturally appropriate resources, is available for patients/residents and families and is easily accessible to staff. Patients/residents and family members are aware of the collection of resources available and qualified health information professional staff is available to assist them with their health information needs. The organization has conducted an organizational health literacy assessment and has a plan in place to address deficiencies.

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Element D: The Practice Team (MUST PASS). The practice uses a team to provide a range of patient care services by:

1. Defining roles for clinical and nonclinical team members.
2. Identifying the team structure and the staff who lead and sustain team based care.
3. Holding scheduled patient care team meetings or a structured communication process focused on individual patient care. (CRITICAL FACTOR)
4. Using standing orders for services.
5. Training and assigning members of the care team to coordinate care for individual patients.
6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change.
7. Training and assigning members of the care team to manage the patient population.
8. Holding scheduled team meetings to address practice functioning.
9. Involving care team staff in the practice's performance evaluation and quality improvement activities.
10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council.

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II.N: Effective 24-hour shift-to-shift and inter-departmental communication processes are in place to ensure patients'/residents' individualized needs are evaluated, discussed, and met. Patients/residents and families are involved in shift-to-shift communication in a manner that meets their individual preferences and needs.

II.F: Formalized processes are in place to promote continuity, consistency and accountability in care delivery, and which allow staff the opportunity and responsibility for personalizing care in partnership with each patient/resident.

I.E: An ongoing mechanism is in place to solicit input and reactions from patients/residents, families, and the community on current practices and new initiatives, and to promote partnership between these stakeholders and the organization's leadership and governing body. This may be achieved via an active patient/resident/ family or community advisory council with regular meetings (at a minimum six times a year) and access to decision-makers, or some other effective mechanism to obtain regular input from patients/residents and community. Participation is representative of the community served.

II.E: Active teams are in place that address patient-/resident-centered initiatives, and include participation by non-supervisory staff and, as appropriate, patients/residents and families.

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PCMH 3: Population Health Management - The practice uses a comprehensive health assessment and evidence-based decision support based on complete patient information and clinical data to manage the health of its entire patient population.

Element A: Patient Information. The practice uses an electronic system to record patient information, including capturing information for factors 1–13 as structured (searchable) data for more than 80 percent of its patients:

1. Date of birth.
2. Sex.
3. Race.
4. Ethnicity.
5. Preferred language.
6. Telephone numbers.
7. E-mail address.
8. Occupation (NA for pediatric practices).
9. Dates of previous clinical visits.
10. Legal guardian/health care proxy.
11. Primary caregiver.
12. Presence of advance directives (NA for pediatric practices).
13. Health insurance information.
14. Name and contact information of other health care professionals involved in patient's care.

VIII.B: Accommodations are made to integrate individual patients'/residents' cultural norms, needs and beliefs into their care and treatment plan upon request.

III.B: A range of educational materials, including consumer health, those designed to accommodate a range of health literacy levels and culturally appropriate resources, is available for patients/residents and families and is easily accessible to staff. Patients/residents and family members are aware of the collection of resources available and qualified health information professional staff is available to assist them with their health information needs. The organization has conducted an organizational health literacy assessment and has a plan in place to address deficiencies.

IX.D- Applies only to acute care and continuing care sites: A plan is developed and implemented for providing holistic and dignified end-of-life care. The plan includes clinical care and pain management, meaningful education about advance directives, and psychosocial and spiritual support.

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Element B: Clinical Data. The practice uses an electronic system with the functionality in factors 6 and 7 and records the information in factors 1–5 and 8–11 as structured (searchable) data.

1. An up-to-date problem list with current and active diagnoses for more than 80 percent of patients.
2. Allergies, including medication allergies and adverse reactions,* for more than 80 percent of patients.
3. Blood pressure, with the date of update, for more than 80 percent of patients 3 years and older.
4. Height/length for more than 80 percent of patients.
5. Weight for more than 80 percent of patients.
6. System calculates and displays BMI.
7. System plots and displays growth charts (length/height, weight and head circumference) and BMI percentile (0-20 years) (NA for adult practices).
8. Status of tobacco use for patients 13 years and older for more than 80 percent of patients.
9. List of prescription medications with date of updates for more than 80 percent of patients.
10. More than 20 percent of patients have family history recorded as structured data.
11. At least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of patients with at least one office visit.

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Element C: Comprehensive Health Assessment. To understand the health risks and information needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes:

1. Age- and gender appropriate immunizations and screenings.
2. Family/social/cultural characteristics.
3. Communication needs.
4. Medical history of patient and family.
5. Advance care planning (NA for pediatric practices).
6. Behaviors affecting health.
7. Mental health/substance use history of patient and family.
8. Developmental screening using a standardized tool (NA for practices with no pediatric patients).
9. Depression screening for adults and adolescents using a standardized tool.
10. Assessment of health literacy.

III.B: A range of educational materials, including consumer health, those designed to accommodate a range of health literacy levels and culturally appropriate resources, is available for patients/residents and families and is easily accessible to staff. Patients/residents and family members are aware of the collection of resources available and qualified health information professional staff is available to assist them with their health information needs. The organization has conducted an organizational health literacy assessment and has a plan in place to address deficiencies.

X.A: Based on the interests and needs of the community, a plan is developed to improve community health. Examples include provision of direct services, educational information, or referral and collaboration with local agencies.

IX.D- Applies only to acute care and continuing care sites: A plan is developed and implemented for providing holistic and dignified end-of-life care. The plan includes clinical care and pain management, meaningful education about advance directives, and psychosocial and spiritual support.

Element D: Use of Data for Population Management (MUST PASS). At least annually the practice proactively identifies populations of patients and reminds them, or

X.A: Based on the interests and needs of the community, a plan is developed to improve community health. Examples include provision of direct services, educational information, or referral and collaboration with local agencies.

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their families/caregivers, of needed care based on patient information, clinical data, health assessments and evidence-based guidelines including:

1. At least two different preventive care services.
2. At least two different immunizations.
3. At least three different chronic or acute care services.
4. Patients not recently seen by the practice.
5. Medication monitoring or alert.

Element E: Implement Evidence-Based Decision Support. The practice implements clinical decision support+ (e.g., point-of-care reminders) following evidence-based guidelines for:

1. A mental health or substance use disorder. (CRITICAL FACTOR)
2. A chronic medical condition.
3. An acute condition.
4. A condition related to unhealthy behaviors.
5. Well child or adult care.
6. Overuse/appropriateness issues.

II.P: Staff engages patients/residents, family and/or their advocates in the care planning process. Examples may include use of shared decision making tools, health coaching and collaborative care conferences.

IX.C: Patients'/residents' health and wellness needs are approached holistically and in consideration of the person's expressed health goals and priorities. Caregivers assess the ability of each patient/resident and family member to self-manage their health care needs, and support is available, as needed, to enhance self-management abilities. Examples include home monitoring, health coach support, programs that support patients/residents/family in chronic disease management, stress management, nutrition, etc.

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PCMH 4: Care Management and Support - The practice systematically identifies individual patients and plans, manages and coordinates care, based on need.

Element A: Identify Patients for Care Management. The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of the following:

1. Behavioral health conditions.
2. High cost/high utilization.
3. Poorly controlled or complex conditions.
4. Social determinants of health.
5. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver.
6. The practice monitors the percentage of the total patient population identified through its process and criteria. CRITICAL FACTOR)

X.C: The organization works with other local healthcare providers across the continuum of care to improve care coordination, communication and information exchanges around the needs of each patient/resident and family, especially during transitions of care.

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Element B: Care Planning and Self-Care Support (MUST PASS). The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in Element A:

1. Incorporates patient preferences and functional/lifestyle goals.
2. Identifies treatment goals.
3. Assesses and addresses potential barriers to meeting goals.
4. Includes a self-management plan.
5. Is provided in writing to the patient/family/caregiver.

Element C: Medication Management. The practice has a process for managing medications, and systematically implements the process in the following ways:

1. Reviews and reconciles medications for more than 50 percent of patients received from care transitions. (CRITICAL FACTOR)
2. Reviews and reconciles medications with patients/families for more than 80 percent of care transitions.

II.P: Staff engages patients/residents, family and/or their advocates in the care planning process. Examples may include use of shared decision making tools, health coaching and collaborative care conferences.

IX.C: Patients'/residents' health and wellness needs are approached holistically and in consideration of the person's expressed health goals and priorities. Caregivers assess the ability of each patient/resident and family member to self-manage their health care needs, and support is available, as needed, to enhance self-management abilities. Examples include home monitoring, health coach support, programs that support patients/residents/family in chronic disease management, stress management, nutrition, etc.

IV.B-Acute Care and Continuing Care Application: A comprehensive formalized approach for partnering with families in all aspects of the patient's/resident's care, and tailored to the needs and abilities of the organization, is developed. An example is a Care Partner Program.

IV.B-Behavioral Health Application: A comprehensive formalized approach to providing families with psychoeducation and, when clinically appropriate, involving them in the patient's care, is developed and tailored to the needs and abilities of the organization. An example is a Care Partner Program.

IX.A: A broad range of healing modalities, including those considered complementary to Western or traditional modalities, are offered to meet the needs of patients/residents. These offerings are based on an assessment of the interests and current utilization patterns of patients/residents and medical staff in such complementary and integrative healing modalities. Examples could include providing direct services, developing a process for responding to patient/resident requests for in-hospital treatment by the patient's/resident's existing practitioner(s), and evaluation of patients/residents' herbal remedies as part of the medication reconciliation process.

III.C: Patients/residents are provided with meaningful discharge/transition instructions in a manner that accommodates their level of understanding and in a language that they understand.

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3. Provides information about new prescriptions to more than 80 percent of patients/families/caregivers.
4. Assesses understanding of medications for more than 50 percent of patients/families/caregivers, and dates the assessment.
5. Assesses response to medications and barriers to adherence for more than 50 percent of patients, and dates the assessment.
6. Documents over-the-counter medications, herbal therapies and supplements for more than 50 percent of patients, and dates updates.

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Element D: Use Electronic Prescribing. The practice uses an electronic prescription system with the following capabilities:

1. More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and electronically sent to pharmacies.
2. Enters electronic medication orders in the medical record for more than 60 percent of medications.
3. Performs patient-specific checks for drug-drug and drug-allergy interactions.
4. Alerts prescribers to generic alternatives.

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Element E: Support Self-Care and Shared Decision Making. The practice has, and demonstrates use of, materials to support patients and families/caregivers in self-management and shared decision making. The practice:

1. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients.
2. Provides educational materials and resources to patients.
3. Provides self-management tools to record self-care results.
4. Adopts shared decision making aids.
5. Offers or refers patients to structured health education programs, such as group classes and peer support.
6. Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates.
7. Assesses usefulness of identified community resources.

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III.B: A range of educational materials, including consumer health, those designed to accommodate a range of health literacy levels and culturally appropriate resources, is available for patients/residents and families and is easily accessible to staff. Patients/residents and family members are aware of the collection of resources available and qualified health information professional staff is available to assist them with their health information needs. The organization has conducted an organizational health literacy assessment and has a plan in place to address deficiencies.

II.P: Staff engages patients/residents, family and/or their advocates in the care planning process. Examples may include use of shared decision making tools, health coaching and collaborative care conferences.

X.A: Based on the interests and needs of the community, a plan is developed to improve community health. Examples include provision of direct services, educational information, or referral and collaboration with local agencies.

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PCMH 5: Care Coordination and Care Transitions - The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.

Element A: Test Tracking and Follow-Up. The practice has a documented process for and demonstrates that it:

1. Tracks lab tests until results are available, flagging and following up on overdue results. (CRITICAL FACTOR)
2. Tracks imaging tests until results are available, flagging and following up on overdue results. (CRITICAL FACTOR)
3. Flags abnormal lab results, bringing them to the attention of the clinician.
4. Flags abnormal imaging results, bringing them to the attention of the clinician.
5. Notifies patients/families of normal and abnormal lab and imaging test results.
6. Follows up with the inpatient facility about newborn hearing and newborn blood-spot screening (NA for adults).
7. More than 30 percent of laboratory orders are electronically recorded in the patient record.
8. More than 30 percent of radiology orders are electronically recorded in the patient record.
9. Electronically incorporates more than 55 percent of all clinical lab test results into structured fields in medical record.
10. More than 10 percent of scans and tests that result in an image are accessible electronically.

X.C: The organization works with other local healthcare providers across the continuum of care to improve care coordination, communication and information exchanges around the needs of each patient/resident and family, especially during transitions of care.

II.K: When an adverse clinical event or unanticipated outcome occurs, a process is in place to provide support to patients/residents, family and staff affected. This includes a process for full and empathetic disclosure to patients/residents (and family as appropriate).

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Element B: Referral Tracking and Follow-Up. The practice:

1. Considers available performance information on consultants/specialists when making referral recommendations.
2. Maintains formal and informal agreements with a subset of specialists based on established criteria.
3. Maintains agreements with behavioral healthcare providers.
4. Integrates behavioral healthcare providers within the practice site.
5. Gives the consultant or specialist the clinical question, the required timing and the type of referral.
6. Gives the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan.
7. Has the capacity for electronic exchange of key clinical information+ and provides an electronic summary of care record to another provider for more than 50 percent of referrals.
8. Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. (CRITICAL FACTOR)
9. Documents co-management arrangements in the patient's medical record.
10. Asks patients/families about self-referrals and

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II.B: Physicians are oriented, regularly educated about, and encouraged to participate in patient-/resident-centered initiatives, and demonstrate behaviors consistent with the organization's culture of patient-/resident-centered care. An independently administered physician engagement survey is conducted at least once every three years using a validated survey instrument, and validates physicians' understanding and engagement in that culture.

III.D: The site has a process to assist patients/residents and families in managing their medical information and coordinating their care among multiple physicians, including their admitting physician, primary care provider and appropriate specialists. An example is providing patient access to personal health information via the organization's electronic patient portal.

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Element C: Coordinate Care Transitions. The practice:

1. Proactively identifies patients with unplanned hospital admissions and emergency department visits.
2. Shares clinical information with admitting hospitals and emergency departments.
3. Consistently obtains patient discharge summaries from the hospital and other facilities.
4. Proactively contacts patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit.
5. Exchanges patient information with the hospital during a patient's hospitalization.
6. Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners.
7. Exchanges key clinical information with facilities and provides an electronic summary-of-care record to another care facility for more than 50 percent of patient transitions of care.

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III.C: Patients/residents are provided with meaningful discharge/transition instructions in a manner that accommodates their level of understanding and in a language that they understand.

X.C: The organization works with other local healthcare providers across the continuum of care to improve care coordination, communication and information exchanges around the needs of each patient/resident and family, especially during transitions of care.

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PCMH 6: Performance Measurement and Quality Improvement - The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.

Element A: Measure Clinical Quality Performance. At least annually, the practice measures or receives data on:

1. At least two immunization measures.
2. At least two other preventive care measures.
3. At least three chronic or acute care clinical measures.
4. Performance data stratified for vulnerable populations (to assess disparities in care).

XI.B-Acute Care Application: The hospital monitors and reports its performance on the full set of CMS Quality Measures to CMS, and shares data on all available indicators with Planetree. The hospital's performance for the most recent twelve month period for which data is available exceeds the "National Average" performance as reported on the U.S. Department of Health and Human Services Hospital Compare web site on 75% of the indicators for which the hospital has more than 25 eligible patients for the 12 month period (an n of >25).

Element B: Measure Resource Use and Care Coordination. At least annually, the practice measures or receives quantitative data on:

1. At least two measures related to care coordination.
2. At least two utilization measures affecting health care costs.

IX.C: Patients'/residents' health and wellness needs are approached holistically and in consideration of the person's expressed health goals and priorities. Caregivers assess the ability of each patient/resident and family member to self-manage their health care needs, and support is available, as needed, to enhance self-management abilities. Examples include home monitoring, health coach support, programs that support patients/residents/family in chronic disease management, stress management, nutrition, etc.

X.C: The organization works with other local healthcare providers across the continuum of care to improve care coordination, communication and information exchanges around the needs of each patient/resident and family, especially during transitions of care.

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Element C: Measure Patient/Family Experience. At least annually, the practice obtains feedback from patients/families on their experiences with the practice and their care.

1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories:

- Access.
 - Communication.
 - Coordination.
 - Whole person care/self-management support.
2. The practice uses the PCMH version of the CAHPS Clinician & Group Survey Tool.
3. The practice obtains feedback on experiences of vulnerable patient groups.
4. The practice obtains feedback from patients/families through qualitative means.

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XI.A-Acute Care Application: Patient experience (both inpatient and outpatient) is regularly assessed using a validated survey instrument, which includes the HCAHPS questions. HCAHPS performance for the most recent 12 months for which data is available satisfies each of the following:

· The hospital's aggregate performance on the eight composite questions exceeds the national aggregate performance. (Aggregate score can be calculated by averaging mode-adjusted top box scores for the eight questions; scores will be rounded to the nearest whole percentage point.)

· Performance on each publicly reported category falls no lower than seven percentage points below the national average.

Performance on the overall rating question exceeds the national average.

I.C: Patient/resident, family and staff focus groups are conducted on-site by Planetree or another qualified, independent vendor periodically (recommended interval is at least every 18 months), and the results are shared at a minimum with senior management, the governing body, and staff.

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Element D: Implement Continuous Quality Improvement (MUST PASS). The practice uses an ongoing quality improvement process to:

1. Set goals and analyze at least three clinical quality measures from Element A.
2. Act to improve at least three clinical quality measures from Element A.
3. Set goals and analyze at least one measure from Element B.
4. Act to improve at least one measure from Element B.
5. Set goals and analyze at least one patient experience measure from Element C.
6. Act to improve at least one patient experience measure from Element C.
7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations.

XI.D: Staff and patient/resident/family members are actively involved in the design, ongoing assessment and communication of performance improvement efforts. The organization consistently utilizes data to identify and prioritize improvement over time.

I.D: Information on patient-/resident-centered care implementation and related clinical, operational and financial metrics is shared with all key organizational stakeholders, including the governing body, at a minimum quarterly. Goals and objectives related to patient-/resident-centered care are adopted as part of the organization's strategic and/or operational plan

Element E: Demonstrate Continuous Quality Improvement. The practice demonstrates continuous quality improvement by:

1. Measuring the effectiveness of the actions it takes to improve the measures selected in Element D.
2. Achieving improved performance on at least two clinical quality measures.
3. Achieving improved performance on one utilization or care coordination measure.
4. Achieving improved performance on at least one patient experience measure.

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Element F: Report Performance. The practice produces performance data reports using measures from Elements A, B and C and shares:

1. Individual clinician performance results with the practice.
2. Practice-level performance results with the practice.
3. Individual clinician or practice-level performance results publicly.
4. Individual clinician or practice-level performance results with patients.

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Element G: Use Certified EHR Technology. The practice uses a certified EHR system.

1. The practice uses an EHR system (or modules) that has been certified and issued a CMS certification ID.
2. The practice conducts a security risk analysis of its EHR system (or modules), implements security updates as necessary and corrects identified security deficiencies
3. The practice demonstrates the capability to submit electronic syndromic surveillance data to public health agencies electronically.
4. The practice demonstrates the capability to identify and report cancer cases to a public health central cancer registry electronically.
5. The practice demonstrates the capability to identify and report specific cases to a specialized registry (other than a cancer registry) electronically.
6. The practice reports clinical quality measures to Medicare or Medicaid agency, as required for Meaningful Use.
7. The practice demonstrates the capability to submit data to immunization registries or immunization information systems electronically.
8. The practice has access to a health information exchange.
9. The practice has bidirectional exchange with a health information exchange.

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XI.B-Acute Care Application: The hospital monitors and reports its performance on the full set of CMS Quality Measures to CMS, and shares data on all available indicators with Planetree. The hospital's performance for the most recent twelve month period for which data is available exceeds the "National Average" performance as reported on the U.S. Department of Health and Human Services Hospital Compare web site on 75% of the indicators for which the hospital has more than 25 eligible patients for the 12 month period (an n of >25).

XI.B-Behavioral Health Application: The hospital monitors and reports its performance on appropriate quality measures and provides benchmarks for comparison purposes. The hospital meets or exceeds benchmarks. Sites accredited by The Joint Commission may submit their ORYX Performance Measure Report, with both the control chart to demonstrate internal trending and the comparison chart to demonstrate performance that meets or exceeds benchmarks to satisfy the criteria.