

Patient Centered Medical Home (PCMH)

PCMH Foundation

PCMH-101

Objective

Practice unit has developed PCMH-related patient communication tools. An established process is in place to discuss the Patient-Provider Partnership (PPP) with patients on a regular basis and document this discussion.

Policy/Process/Procedures

Patients are provided with Patient-Provider Partnership (PPP) materials. A knowledgeable member of the practice unit reviews the partnership expectations with the patient, including both patient and provider responsibilities, and documents completion of the discussion in the medical record. Patients are encouraged to direct questions to clinical staff or their provider at any time.

Documentation Requirements

The date of the Patient-Provider Partnership (PPP) discussion is documented in the medical record.

Timeframes & Frequency

The PPP information and discussion are reviewed at every new patient visit, annual wellness visit/or and physical or at a minimum every 1–3 years.

Tools & Resources

Patient-Provider Partnership (PPP) material; i.e. brochure, website, etc.
Patient portal blast included in preventative care services.

Evidence for Site Visit

- Practice has a written process for educating patients on PCMH and the Patient-Provider Partnership
- Documentation of the discussion
- Review PCMH patient education tools

PCMH-102

Objective

Practice unit staff members receive regular training and have comprehensive knowledge of key concepts and processes related to patient-centered care. Practice maintains a log of training completion dates for all staff.

Policy/Process/Procedures:

The practice maintains a standardized, comprehensive staff training program designed to support the delivery of high-quality, patient-centered care across the patient population served, including pediatric and adult populations based on the practice specialty. All staff are expected to complete required training(s) within 30 days of hire and annually thereafter, with completion documented through staff and/or provider training logs.

All staff receives training including, but is not limited to

- Patient-Centered Medical Home (PCMH)
- Chronic Care Model
- Practice Transformation Concepts
- Available community resources to be able to educate patients and assess the need for appropriate community resources
- Trainings related to preventative care screenings and applicable guidelines based on the recommendations from organizations such as: Michigan Quality Improvement Consortium (MQIC), the American Medical Association (AMA), and the American Academy of Family Physicians (AAFP)
- Key operational processes including test tracking and specialist referrals

Documentation Requirements

The practice unit will maintain yearly training logs for all staff, including providers, and training(s) must be completed within 30 days of hire and reviewed and updated annually. Training logs include training dates, topics such as - PCMH model, community resources, evidence-based guidelines, and applicable operational workflow, as it relates to both the adult and pediatric population, when applicable. All documentation is retained and available for review.

Timeframes & Frequency

Yearly training will take place for all staff, including providers, and training(s) will be completed within 30 days of hire and reviewed and updated annually

Tools & Resources

- PCMH model

- Chronic Care Model
- practice transformation concepts
- OPNS Community Resources Guide
- Evidence-based guideline sources (e.g., MQIC, AMA, AAFP)
- Preventive care screening guidelines
- Policy/Procedure CC 131 and 132
- PCMH electronic binder

Evidence for Site Visit

- Review the training materials
- Staff training logs reflect completion of required training(s) by staff members within 30 days of hire and on an annual basis thereafter
- Practice has a process to ensure staff training is completed upon new hire and at least annually thereafter

PCMH-103

Objective

Practice unit and/or PO maintain written policy and/or procedure documents for all standardized processes included in the Patient-Centered Medical Home program.

Policy/Process/Procedures

Must be in writing

- Must clearly outline all steps in the standard operating process
- Must include specific timeframes, where applicable
 - Test tracking
 - Specialist referrals
- Patient-provider partnership agreement (PCMH-101)
- PCMH training (PCMH-102)
- Planned care visits (PCMH-104)
- Outreach to patients for gaps in care (PHM-111)
- Medication reconciliation (PHM-112)
- Comprehensive preventive care (PHM-114)
- Community resources coordination (PHM-115)
- Monitoring utilization data (AC-122)
- Same-day appointment scheduling (AC-125)
- Transitions of care management (CC-134)

Documentation Requirements

All policies, processes, and procedures are formally documented in writing. Each document clearly defines its purpose and outlines staff roles and responsibilities within the office setting.

Timeframes & Frequency

- All policy, process, and procedure documents must be reviewed, revised and updated
 - This must occur at least annually

Evidence for Site Visit

- Practice has documented policy/process/procedure for each of the listed topics
- Practice has a process to review documents on an annual basis

PCMH-104

Objective

A standardized process is in place to deliver planned care visits to patients for preventive care and all chronic conditions relevant to practice patient population.

Policy

All patient appointments are tracked, with reminder calls placed two days prior. If an appointment is canceled or rescheduled, the provider is notified and provides direction to internal staff on next steps. For no-shows, three outreach attempts are made on different days and times to reschedule. If unsuccessful, the provider is notified and may elect to send a certified letter. All follow-up actions are documented in the patient's chart.

Follow-up appointments are scheduled at checkout. If a patient declines, a tracking flag is placed to prompt staff outreach if the appointment is not scheduled by a specified date. All staff utilize evidence-based guidelines from the American Medical Association (AMA) and Michigan Quality Improvement Consortium (MQIC) for preventive and chronic care. Care gaps are reviewed at each visit, with providers assessing patient history and health maintenance needs. Additional gap reports are available through HealthFocus.

Planned visits are offered for preventive and chronic care, with extended appointment times dedicated to addressing these needs

Process/Procedure

Individual provider schedules are reviewed and "scrubbed" daily by the assigned Medical Assistant (MA) and/or Registered Nurse/Licensed Practical Nurse (RN/LPN). The MA ensures patient records are prepared to support efficient appointment workflows.

The RN/LPN reviews the schedule to identify patients who may benefit from care management services or who are currently enrolled. For these patients, the RN/LPN collaborates with the provider, and when appropriate, the MA, in a pre-visit huddle to align care needs and next steps.

Before the Visit:

Front Office

- Insurance verification ahead of the visit – will call patient if needed to verify information
- Schedule patient at interval indicated as entered by provider
- Inform patient they must have required lab work or testing at least one week prior to the appointment
- Send a message to clinical staff, if needed, to review chart and add necessary lab and/or testing orders

Medical Assistant (MA) (all patients)

- Huddle – MA, RN/LPN as needed:
 - Discuss questions or concerns with the provider to prepare for the visit either the day before or same day as the appointment
- Chart Preparation:
 - Review the patient chart to ensure all required labs, tests, and results are complete, up to date, and accurately documented
 - Each physician utilizes pre-configured, disease-specific order sets aligned with established evidence-based guidelines for follow-up care
 - Orders are entered for any outstanding or missing required testing and identified quality measures or care gaps
 - Relevant clinical notes and reminders are documented based on discussions with the provider
 - MCIR records are reviewed, and appropriate orders are added for outstanding immunizations (e.g., pneumococcal, influenza, COVID-19, shingles, hepatitis), with provider review and signature obtained as required
 - Allergy and medication lists are reconciled with incoming information and updated as appropriate
 - RN/LPN support is prioritized for patients identified as needing, or currently enrolled in, Care Management services

During the visit:

- Front Office/Check-in
 - Greet the patient and assist with check-in
 - Patients are provided with all required surveys and forms as appropriate
 - Insurance coverage is verified and updated as needed to ensure accurate and current information
- MA
 - Greet the patient in the waiting room
 - Walks the patient to the exam room
 - Obtains and documents vital signs, including height, weight, blood pressure, heart rate, respiratory rate, pulse ox, temperature
 - Verifies and documents chief complaint/reason for visit in the chart
 - Enters current symptoms or concerns into the medical record
 - Reviews medication list
 - Reviews history – personal, family and social
 - Notify provider the patient is ready to be seen
- RN/LPN

- Based on the pre-visit huddle, the RN/LPN may see the patient before or after the provider to provide disease and medication education, coordinate follow-up, and facilitate introduction to or enrollment in care management programs
 - The RN/LPN may also support care coordination during the visit based on patient needs or provider direction
- Provider
 - Review and reconcile the patient's medication list, including medications prescribed by external providers, and update as appropriate
 - Complete and document the History of Present Illness (HPI) and Review of Systems (ROS)
 - Review and verify documentation received from external providers
 - If a Care Management referral is not in place or the patient is not actively enrolled, discuss the program with the patient and initiate a referral as appropriate
 - Provide both written and verbal education on preventive care, diabetes management, and tobacco cessation
 - Enter referrals, as appropriate, to external resources such as education programs, nutrition services, and specialty care
 - Confirm patient understanding using the teach-back method, asking the patient to restate instructions in their own words
 - Communicate the appropriate follow-up timeframe to the patient and document it in the medical record
 - Enter a tracking flag in the system to support scheduling, reminders, and follow-up activities

After the visit:

- Front Office
 - Schedules follow-up appointment at the time of checkout as indicated by the provider
- MA
 - Maintain ongoing coordination with the provider and/or RN/LPN to ensure timely medication refills
 - Maintain ongoing coordination with the provider and/or RN/LPN to ensure completion of care at external facilities, including follow-up outreach as needed
- RN/LPN

- o If a Care Management referral is initiated during the visit, or if the patient is already enrolled, care is provided telephonically, in-person, or via telemedicine, based on patient needs.
 - Patients enrolled in longitudinal programs (e.g., PDCM or CCM) receive care management services at least monthly or as needed
 - For episodic follow-up, the nurse receives the referral, completes an assessment, and establishes an appropriate follow-up plan. With patient agreement, the patient is scheduled and followed until goals are achieved or the patient elects to discontinue participation
 - The care manager coordinates care with specialists, as needed, ensuring appointments are completed, and consult documentation is received and reviewed in a timely manner. The nurse may also assist with coordinating durable medical equipment (DME) and medication refills or adjustments between visits.
- Physician/NP/PA
 - o The provider reviews results, consult notes, medications, DME, and refill requests between visits and directs the RN/LPN or MA on appropriate next steps
 - o Ongoing communication among the provider, MA, and nursing staff supports coordinated, patient-centered care, led by the physician

Documentation Requirements

All appointment activities, follow-up, and planned visits, including outreach attempts, are documented within the appointment tracking system.

For planned visits, all steps are thoroughly documented by the appropriate staff

Timeframes & Frequency

Planned visits can be made at every visit or when applicable

Tools & Resources

Planned visit template

References / Guidelines Alignment

American Medical Association (AMA), Michigan Association of Health Plans which holds the Michigan Quality Improvement Consortium (MQIC) Guidelines.

Evidence for Site Visit

- Practice has a process that outlines roles and responsibilities for planned visits, specified by type of visit (preventive vs. chronic condition)
- Practice has a process for appointment tracking and reminders
- Practice has a process to follow up with patients who miss appointments

Population Health Management (PHM)

PHM-111

Objective

A population health management tool is being used proactively and at point of care.

Policy/Process/Procedure

The practice utilizes a population health management tool (HealthFocus or practice units electronic medical record) to support proactive identification and management of patient care needs, outreach efforts, and care opportunities across the patient population. The tool integrates structured clinical data from the practice's medical records, reports received directly from health plan payers, and/or historical payer claims data. Evidence-based care guidelines are utilized to identify gaps in care for chronic conditions relevant to the patient population, as well as preventive health services. Population health information is accessible to the practice unit team at the point of care and is routinely used to support patient outreach and care coordination activities.

Timeframes & Frequency

Gap-in-care reports are reviewed daily, or as needed, to support proactive outreach and effective management of the patient's population.

Tools & Resources

- Health Focus Registry
- Practice EMR

References / Guidelines Alignment

- National Committee for Quality Assurance (NCQA)
- Healthcare Effectiveness Data and Information Set (HEDIS)

Evidence for Site Visit

- Discuss what clinical and patient data is included in database, how data is entered or flows into the population health tool, and how data is displayed in database
- Demonstrate how database is used at point of care and proactively to manage healthcare of population in accordance with written process document

PHM-112

Objective:

A standard process is in place for clinical staff to complete a full review of patient medication lists during every appointment, updating the patient's medical record as indicated.

Policies/Process/Procedure:

Process for clinical staff to complete a comprehensive review of the patient's medication list during every patient appointment type, including in-person, virtual, and telephonic visits.

- At each appointment, the patient's current medication and supplement list, including strength and dosage, is reviewed and updated by clinical staff, with final review completed by the Primary Care Provider (PCP)
 - Medication interactions and/or possible side effects the patient presents at the visit are documented and discussed with the PCP
 - The PCP will review and adjust medications based on the patient's current medical conditions, which may include initiating, discontinuing, or modifying medication dosage and/or frequency
- Medication Reconciliation Post In-Patient Discharge
 - Completed on the date of the patient's discharge through 30 days after discharge (31 days total)
 - Conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse. Other staff members (e.g., MA or LPN) may conduct the medication reconciliation, but it must be signed off by the required practitioner type

Timeframes & Frequency

A comprehensive medication review is completed during every patient encounter, including in-person, virtual, and telephonic visits. Medication reconciliation is completed during all post-discharge appointments.

Tools & Resource

Reported CPT II code: 1159F Medication list documented in medical record

Reported CPT II code: 1160F Review of all medications by a prescribing practitioner or clinical pharmacist

Reported CPT II code: 1111F Medication Reconciliation was performed post discharge from inpatient stay

OPNS TCM Checklist

OPNS TCM Contacting Patients Hospital Discharge Process

Post Discharge Criteria and Medication Reconciliation

References/Guidelines

HEDIS MY 2026 Volume 2 Publication October 2025

CMS MLN Transition Care Management Services Booklet 2025

NCQA Documentation Criteria

American Medical Association (AMA)

Michigan Association of Health Plans which holds the Michigan Quality Improvement Consortium (MQIC)

Evidence for Site Visit

- Practice demonstrates active use of their medication reconciliation procedure document
- Document includes steps on process for medication reconciliation as part of transitions of care

PHM-113

Objective

Practice unit has access to interpreter(s) in the languages commonly spoken by their patient population.

Policy/Process/Procedure

N/A

Documentation Requirements

If interpreter services are needed the following should be documented in the patients medical record:

- patient's preferred language should be documented
- Whether interpreter services were offered
- Whether interpreter services were accepted or declined
- Type of interpreter used: phone, in-person, telemedicine
- Interpreter identification number or name

Timeframes & Frequency

N/A

Tools & Resources

Oakland Physician Network Services Website: opns.org

References / Guidelines

- Ensure office staff reviews preferred language and interpreter need fields into intake workflow.
- Reassess interpreter needs periodically, especially for new patients
- Flag interpreter needs in the medical record or demographic section

Evidence for Site Visit

- Practice demonstrates how patient language is assessed and documented in patient chart, including documentation if interpreter services are needed for patient
- Discuss process to provide language services if needed

PHM-114

Objective

Practice has a standard process to provide comprehensive preventive care for all patients.

Policy/Process/Procedure

The practice utilizes evidence-based care guidelines from the American Medical Association (AMA) and Michigan Quality Improvement Consortium (MQIC) to support preventive care and chronic condition management. MQIC alerts are routinely monitored by the physician organization and/or practice unit to ensure timely implementation of guideline and measure updates.

Health and family history are obtained and documented during the initial patient visit and reviewed annually thereafter by clinical staff. Information collected is used to assess personal health behaviors, identify care needs, and determine appropriate preventive services, screenings, immunizations, referrals, and follow-up care. Preventive, secondary, and tertiary screenings are performed based on patient need and may include, but are not limited to, tobacco use, depression, anxiety, social determinants of health, cancer screenings, and fall risk assessments.

Alerts, questionnaires, family history, and identified gaps in care are reviewed at the point of care to support patient education, preventive counseling, and care planning. Patients identified as high-risk or with positive screening results are referred for appropriate services and monitored through follow-up outreach to ensure care needs are addressed. Unresolved referrals, results, or patient care concerns are escalated to the provider for further direction as needed.

Documentation Requirements

Screenings performed, including documentation of positive findings and appropriate follow-up actions.

Timeframes & Frequency

Screenings are completed at a minimum annually during the patient's annual visit and more frequently as clinically indicated or directed by the physician.

Tools & Resources

Evidenced Based Care Guidelines (EBCG) screening questionnaires for all health/family history and each tool used at all wellness visits.

References/Guidelines Alignment

American Medical Association (AMA)
Michigan Association of Health Plans which holds the Michigan Quality Improvement Consortium (MQIC) Guidelines

Evidence for Site Visit

- Practice has a written process for providing comprehensive primary care that includes administering assessments that are guideline-based (including tobacco use, depression, and lung cancer when applicable based on age, gender, medical history, etc.)
- Practice discusses process for adjusting the timeline of patient care gaps based on clinical indicators (e.g., accelerated timeline for patients' colorectal cancer screening based on increased patient risk)
- Discuss process for generating and disseminating guideline-based care reminders

PHM-115

Objective

Practice has a standard process to educate patients on the availability of community resources and to provide referrals for patients who indicate a need.

Policy

Process/Procedure

The practice unit and/or physician organization maintains a community resource directory that includes geographically relevant community resources and is reviewed and updated annually.

A standardized process is utilized to educate patients on available community resources and assess psychosocial and community resource needs during new patient visits and annually thereafter by implementing an evidence-based screening tool to identify those who need assistance.

All practice staff are encouraged to identify and communicate potential patient needs to appropriate practice unit staff. Patients expressing interest in community resource assistance are referred through a standardized referral process, with assessments and referrals documented in the medical record.

The practice unit maintains a standardized, documented process to assess community needs for resources, educate patients on available resources, and refer patients to appropriate community services. This process is routinely used by the care team and documented in the medical record for all eligible patients

Documentation Requirements

Evidence Based Screening Tool; such as AAFP
Documentation of social needs assessment
Resource education provided
Referral made or declined

Timeframes & Frequency

Screening is facilitated at least annually during annual well visits/physicals or during new patient visits

Tools & Resources

OPNS Community Resource Directory
AAFP screening tool

Evidence for Site Visit

- Display community resource repository and discuss how it is maintained and updated

- Practice provides written documentation of screening and referral workflow, as well as patient examples of screening (positive and negative) and documentation of education provided for positive screens

Access to Care (AC)

AC-121

Objective

Patients have 24-hour access to a clinical decision-maker by phone, and the clinical decision-maker follows up in a timely manner and accesses and updates the patient's medical record with the instructions to the patient.

Policy/Process/Procedure

N/A

Documentation Requirements

N/A

Timeframes & Frequency

N/A

Tools & Resources

N/A

References/Guidelines Alignment

The practice unit provides patients with 24-hour access to a clinical decision-maker for urgent clinical needs. After-hours interactions are communicated to the patient's PCP within 24 hours or the next business day, and the medical record is updated to support continuity of care and appropriate follow-up.

Evidence for Site Visit

Practice has a process to inform patients of the availability of a 24-hour clinical decision-maker.

AC-122

Objective

Practice has a standardized process to monitor urgent care and emergency department utilization, in an effort to, reduce inappropriate utilization.

Policy/Process/Procedure

The practice unit and/or physician organization systematically reviews available utilization data to evaluate emergency department and urgent care activity, identify potentially avoidable utilization, and recognize patients with recurring utilization patterns. Identified encounters are assessed for appropriate follow-up, care coordination, patient outreach, and scheduling needs to support effective management within the primary care setting and promote improved utilization outcomes.

Documentation Requirements

N/A

Timeframes & Frequency

The practice unit can review the ADT feeds on HealthFocus daily to be able to track and outreach patients who are being discharged from an inpatient facility.

The physician organization (PO) provides practice units with utilization reports identifying patients with frequent emergency department visits or hospital admissions, including potentially avoidable utilization patterns. PO-level utilization data is distributed quarterly, or more frequently as updated data becomes available, to support care coordination and targeted intervention efforts.

Tools & Resources

- HealthFocus Registry
 - ADT feeds
- Reports distributed by the Physician Organization
 - Reports based on claims data from health plan payers

References / Guidelines Alignment

N/A

Evidence for Site Visit

- A written policy/procedure that monitors urgent care and emergency department utilization.
- Practice has a process to identify frequent fliers with high utilization

AC-123

Objective

Patients are educated on how to contact the practice/primary care provider (PCP) to direct after-hours care to the appropriate level of service, in an effort to reduce inappropriate utilization of emergency department and urgent care.

Policy/Process/Procedure

N/A

Documentation Requirements

N/A

Timeframes & Frequency

N/A

Tools & Resources

- 'Call Us First' campaigns
- Patient-Provider Partnership (PPP) brochure
- Patient education materials on conditions appropriate for primary care, urgent care and emergency department
 - Additional support is provided to those patients who have been identified as 'frequent flier' or 'high utilizer'

References / Guidelines Alignment

N/A

Evidence for Site Visit

- Practice has established a process to educate patients on where to go for primary care sensitive encounters
- Documentation provided to patients with after-hours options

AC-124

Objective

PO and/or practice has arranged for patients to have access to a non-ED after-hours provider for urgent care needs in the practice or at another location.

Policy/Process/Procedure

The practice unit maintains a standardized process to obtain clinical information following urgent care encounters to support timely review, care coordination, and follow-up with the patient's primary care provider, as clinically appropriate.

Documentation Requirements

N/A

Timeframes & Frequency

N/A

Tools & Resources

- Patient education materials on preferred urgent care locations

References / Guidelines Alignment

After-hours are defined as outside of regular practice business hours

- Services provided by the after-hours provider must be billable as an office visit or urgent care visit, not as an ER visit.

Evidence for Site Visit

- Process is established to educate patients on after-hour options and obtain clinical information for follow up

AC-125

Objective

Same-day appointments are available to patients for acute and/or routine care.

Policy/Process/Procedure

All practice unit staff are educated on same-day appointment access processes and are aware of the availability of both virtual and in-person appointments to accommodate patients with urgent and routine care needs.

Same-day appointments may be used for:

- Post-Discharge / Transitional Care
- Acute/Sick visits
- Emergency Department/Urgent Care Visits
- Chronic condition follow-up visits

Patients are educated about same-day appointment availability through:

- Website homepage
- On-hold phone messages
- Patient portal
- Office signage
- Text/email reminders, such as
 - “Need care sooner? Ask us about same-day visits.”

Documentation Requirements

N/A

Timeframes & Frequency

N/A

Tools & Resources

N/A

References / Guidelines Alignment

Evidence for Site Visit

- A written policy/procedure is available to include patients who are aware of same-day appointments, and staff are educated on appropriate accommodations.
- Review practice appointment types or schedule

Coordination of Care (CC)

CC-131

Objective

A standardized tracking process is in place to ensure that needed tests are completed; results are received, and patients are notified of results in a timely manner.

Policy/Process/Procedure

Test Tracking Best Practices

Every test must be tracked from:

Order → Completion → Result → Patient Notification → Follow-up

Result Receipt

- STAT/Urgent tests: same day within 24 hours
- Routine labs: within 24–72 hours via phone call, patient portal, and/or email
- Imaging/complex diagnostics: within 3–7 days

Provider Review

- Urgent/critical results: same day (within 24 hours)
- Routine results: within 1–3 business days of receipt

Patient Notification

- Critical results: immediate (same day, documented live contact) via phone call
- Abnormal (non-critical): within 24–48 hours via phone call, patient portal, and/or email
- Normal results: within 3–5 business days via phone call, patient portal, and/or email

If results not received:

- Initial follow-up for either lab or imaging: at expected turnaround + 1–2 days via phone call, patient portal, and/or email
- Continued follow-up: every 2–3 days until resolved via phone call, patient portal, and/or email

Documentation Requirements

Results and follow up action(s) are documented in the patient's medical record

Timeframes & Frequency

As indicated above under policy/process/procedure

Tools & Resources

Tracker for lab results and outreach to patient(s) are documented and updated in a timely manner according to the timelines indicated above

References / Guidelines Alignment

NCQA guidelines

Evidence for Site Visit

- Practice has a policy for ensuring ordered labs and tests are completed
- Practice policy includes identified timeframes for notification of normal, abnormal, and critical results
- Practice has established a process to educate patients on how to obtain results.
- Necessary follow-up is ordered and communicated to the patient

CC-132

Objective

Process is in place for referrals to specialists for clinical evaluation deemed necessary by the PCP. PCP reviews consult test results and consultation notes when provided by the specialist. Patients are notified if follow up is required by the PCP.

Policy/Process/Procedure

Specialist Referral Follow Up Best Practices

Track referrals from:

Order → Appointment → Specialist Visit → Report Received → PCP Review → Patient Follow-Up

Order

- Practice unit provides patient with information regarding specialist referral including:
 - Specialist Name
 - Reason for referral
 - Routine or Urgent referral
 - If patient is required to make the appointment or if practice unit can assist with making the appointment

Referral Scheduling

- Urgent referrals: within 24–48 hours from the time of referral
- Routine referrals: within 3–7 days from the time of referral
 - Patient to contact referring provider, or primary care provider (PCP) if unable to see specialist within one week of referral

Follow-Up on Unscheduled Referrals

- If patient has not scheduled:
 - First outreach: within 3–5 days via phone, patient portal and/or email
 - Additional attempts: weekly x 2–3 attempts phone, patient portal and/or email

Specialist Visit Completion

- Should occur based on urgency:
 - Urgent: within 1–7 days from date of referral

- Routine: within 2–4 weeks from date of referral

Receipt of Specialist Report

- Expected within:
 - 7–14 days after visit with the specialist
- If not received:
 - Follow-up with specialist: within 3–5 days after expected receipt
 - Continue outreach until report obtained

PCP Review of Specialist Report

- If normal, within 3–5 business days
- If critical/abnormal, same day as report was given to PCP

Patient Follow-Up After Specialist Visit

- Within 3–7 days of report review (sooner if urgent changes)

Documentation Requirements

N/A

Timeframes & Frequency

As indicated above under policies/procedures/processes

Tools & Resources

Tracker for specialist referral and outreach to patient(s) are documented and updated in a timely manner according to the timelines indicated above

References / Guidelines Alignment

NCQA guidelines

Evidence for Site Visit

- Practice has a policy to ensure clinically relevant SCP referrals are completed. Policy includes provider notification if referral is not completed to determine if the referral is still indicated
- Process includes PCP review of consult and needed follow up is communicated to the patient
- Practice unit determines the tracking mechanism and timeframes for follow up to be included in the specialist referral policy

CC-133

Objective

A process is in place to identify patients who are in crisis and refer them to appropriate resources. Practice ensures follow-up occurs on a timely basis.

Policy/Process/Procedure

The practice maintains a standardized process to identify patients experiencing behavioral, psychosocial, or medical crises, facilitate referral to appropriate emergency, behavioral health, or community-based resources, and ensure timely follow-up and care coordination.

Patients identified as experiencing a crisis are tracked through established medical record, registry, or care management workflows to support timely outreach, follow-up, referral coordination, and ongoing monitoring until identified needs are addressed or resolved.

Documentation Requirements

Clinical staff documents crisis-related encounters and interventions in the medical record in a timely manner, updates the patient record as clinically appropriate, and ensures the provider is notified to support ongoing care coordination and follow-up.

Timeframes & Frequency

Patients identified as high risk for clinical or psychosocial decompensation receive timely follow-up after referral to critical community or clinical resources. Follow-up outreach is conducted within 24–72 hours, or sooner based on patient acuity, to confirm engagement with the referred service, assess barriers, and support adherence to the plan of care.

Tools & Resources

- Emergency department referral
- 988 crisis line
- Behavioral health specialist
- Psychiatric services
- Social work or care management
- Community resource organizations
- Mobile crisis teams
- APS/CPS referrals when appropriate

References / Guidelines Alignment

Evidence for Site Visit

- Practice will determine what the patient scenario requires and should identify appropriate staff to manage referrals, outreach, and follow up. This may be included in their community's resource protocols.

CC-134

Objective:

Patient transitions are well-managed, and patient care is coordinated across health care settings, through a process of active communication and collaboration among providers, patients, and caregivers.

Policy/ Process/Procedure:

The practice unit maintains a standardized process for monitoring and managing Admission, Discharge, and Transfer (ADT) notifications for all attributed patients to support timely transitions of care and reduce risk of readmission. ADT reports are reviewed daily through the HealthFocus registry and Michigan Statewide Admission, Discharge, Transfer Notification and Exchange dashboards to identify patients recently discharged from an inpatient setting. Initial outreach is completed within 1–2 business days post-discharge to assess the patient’s status, reinforce discharge instructions, reconcile medications, and schedule a post-discharge follow-up appointment with their primary care provider (PCP). Multiple outreach attempts are made at varying times and days when needed, with provider notification and written communication initiated for patients who cannot be reached telephonically.

Post-discharge follow-up appointments are completed within 7–14 calendar days from date of discharge, or, at the very least, patient engagement facilitated within 30 days of discharge through an office or home visit, or telehealth encounter, when appropriate. The medical record includes documentation of the discharge date and facility, outreach attempts, patient contact, medication reconciliation, discharge diagnoses, testing, and all relevant hospitalization records.

Care managers and clinical staff educate patients on the importance of timely follow-up to reduce complications and prevent avoidable rehospitalizations. Payer case managers are engaged as appropriate for patients with complex, chronic, or catastrophic conditions requiring additional care coordination or community-based support services.

Tools & Resources:

OPNS Admission Discharge Log
OPNS TCM Facesheet
TCM Checklist
TCM Post Discharge Process and Medication Reconciliation
TCM Post Discharge Phone Call Dialogue

References:

- Medicare Learning Network (MLN) 2025
- HEDIS 2026 Technical Specifications for Medication Reconciliation and Patient Engagement

Evidence for Site Visit:

- Practice has an ADT notification process that includes documentation in the medical record within specified timeframes to support TOC. (24-48 hours)
- Practice has a process to provide relevant health information (problem/diagnosis, medications, allergies, current lab/test result) that a provider would need to safely assume care of the patient
- Practice has access to payer case managers to support patients in need

Process Improvement (PI)

PI-141

Objective

Performance reports are generated, enabling POs and providers to monitor their population level performance over time, close gaps in care, and improve patient outcomes for chronic conditions and preventive services.

Policy/Process/Procedure

Documentation Requirements

- Performance Reports given to practice unit by physician organization
- Quality gaps in care reports via HealthFocus registry and/or practice units' population health management electronic medical record

Timeframes & Frequency

- Daily gaps in care reports via HealthFocus or practice units' population health management electronic medical record
- Cost and Utilization data quarterly or as needed provided by physician organization

Tools & Resources

- HealthFocus Registry
- Analytic Reporting from PO

References / Guidelines Alignment

The practice unit and/or physician organization utilizes standardized population health reporting processes to monitor quality, utilization, and preventive care performance across the attributed patient population. Reports are developed on a routine basis and include actionable clinical and quality data spanning patients of all ages, including chronic disease management and preventive health measures aligned with recognized evidence-based standards. Data is routinely analyzed and verified for integrity to support performance improvement activities, provider education, and identification of care opportunities. A centralized system is maintained for storage and ongoing access to performance reporting and related quality data.

Evidence for Site Visit

- Practice must provide the source of the reports and explain how they are utilized to identify areas of opportunity and data validation

PI-142

Objective

Practice monitors patient experience data and identifies opportunities for improvement related to office efficiency and quality of care.

Policy/Process/Procedure

Documentation Requirements

- Copy of survey questionnaire with results

Timeframes & Frequency

- Annually

Tools & Resources

- CAHPS Survey
- PO Sponsored Survey
- Practice Unit Survey

References / Guidelines Alignment

The practice unit and/or physician organization consistently evaluates patient experience and practice operational performance measures to support continuous quality and service improvement efforts. Patient feedback information may be gathered through practice-based surveys or physician organization-facilitated assessment tools, including recognized patient experience frameworks such as CAHPS.

Evaluated measures assess patient satisfaction, access to services, office workflows, communication, and the care team's ability to support patients in achieving self-management and health goals. Areas identified for enhancement are reviewed by leadership and staff, with targeted interventions, workflow modifications, and operational improvements implemented as appropriate to strengthen patient engagement, office efficiency, and overall care delivery.

Evidence for Site Visit

- Practice must provide the source of the reports and explain how they are utilized to identify areas of opportunity and data validation

Patient Centered Care (PCC)

PCC-151

Objective

Practice has a process to identify patients who would benefit from ongoing support based on clinical conditions, non-medical drivers of health or patient readiness to improve health outcomes.

Policy/Process/Procedure

The practice unit maintains a structured approach to recognize patients who may require enhanced ongoing clinical, behavioral, or care coordination services to support compliance with the established treatment plan and improve overall health outcomes. Patients may be identified through newly diagnosed chronic conditions, social or economic barriers impacting care, willingness to pursue health or lifestyle modifications, or recurring emergency department and urgent care utilization patterns.

Following identification, the practice facilitates appropriate interventions, patient education, community resources, and care management support to address individualized medical and psychosocial needs while promoting patient engagement, self-management, and continuity of care.

Documentation Requirements

Timeframes & Frequency

Tools & Resources

- AAFP Survey's
- PHQ 2/9 Survey's
- Functional Assessment
- Annual Wellness Visits
- Recent Hospitalizations/Transitions of Care Appointments

References / Guidelines Alignment

Evidence for Site Visit

- Practice has a process to identify patients in need of additional support
- Practice has identified roles and responsibilities of care team members to support patient needs

PCC-152

Objective

For patients who need additional support, written action or treatment plans are developed and incorporated into the medical record with patient specific goals.

Policy/Process/Procedure

Providers and clinical care team members utilize patient-centered goal-setting techniques to develop individualized action plans and treatment goals for patients requiring additional support. Care plans and goals are documented in the medical record to support ongoing follow-up and continuity of care. Self-management support is provided through the patient's preferred communication method, including in-person, virtual, portal, or telephone outreach, and patients receive documentation of the agreed-upon plan of care and goals.

Documentation Requirements

Timeframes & Frequency

Tools & Resources

References / Guidelines Alignment

Evidence for Site Visit

- Documentation in the patient's medical record of current action plan/treatment goals is required to ensure follow up by the provider at the next visit.
- Action/treatment plan is provided to the patient