The Joint Commission

Integrated Care Certification Review Process Guide

2024

Integrated Care Certification

Review Process Guide for Organizations

2024

What's New in 2024

New or revised content for 2024 is identified by underlined text in the activities noted below.

Changes effective January 1, 2024

No changes.

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Integrated Care Certification Overview

The focus of the Integrated Care certification program is to provide a pathway for clinical care partners across settings to demonstrate that they can come together and deliver clinically integrated care, treatment and services with the common goal of improving patient outcomes. The standards focus on establishing the structures, processes, and culture that can lead to improved outcomes.

The goals for certified organizations include the following:

- Establish a strong foundation for care coordination and clinical integration
- Demonstrate the capacity to efficiently coordinate and integrate patient care, treatment, and services
- Decrease variation in the management of chronic diseases and increase adherence to well-researched, evidence-based clinical practices
- Build upon what the organization's providers are currently doing for patient care, treatment, and services and strengthen their capacities to support patients as they move among providers and back home

The on-site certification review is performed by two clinical reviewers and is generally two-days in duration. The length of the review can be impacted by the number of sites in the program and the distance between those sites.

Reviewers will be listening and looking for evidence related to the foundation building that is necessary for successful integration. Several opportunities during the on-site review offer a chance for group discussions to explore the design and implementation of the program with administrative and clinical leaders, front-line providers and with patients. The certification review process also uses the tracer methodology, but with a specific focus on evaluating the processes and culture that are critical to clinical integration and patient-centered care. Tracer activity is used to explore the structures and processes that have been implemented to support provider communications regarding patients, access to information for providers and patients, availability of and patient access to needed care, treatment and services, patient and family engagement, coordination of care, and performance measurement and improvement efforts that span the program's continuum of care.

Organization Review Preparation

The Integrated Care Certification Review Process Guide describes each activity of the Joint Commission onsite certification review. Organizations should read each of the following activity descriptions, which include:

- The purpose of the activity
- Descriptions of what will happen during the activity
- Discussion topics, if applicable
- Recommended participants
- Any materials required for the session

Share these descriptions organization-wide, as appropriate.

Pre-Review Phone Call
A Joint Commission account executive will contact your organization by phone shortly after receiving your application for certification. The purpose of this call is to:

- Confirm information reported in the application for certification including the clinical care partners and sites that are included in the program
- Verify travel planning information and directions to main location for review,
- Confirm your access to The *Joint Commission Connect* extranet site and the certification-related information available there (onsite visit agenda, Certification Review Process Guide, etc.), and
- Answer any organization questions and address any concerns.

Notice of Initial Certification Onsite Review
If this is your program's first time through the certification process you will receive at least a 30-day advance notice of your onsite review date(s). The Notification of Scheduled Events link on your organization's extranet site, The *Joint Commission Connect*, is populated with the review date, reviewer's name, biographical sketch and picture 30 days prior to the review date. The account executive can answer questions about the process or put you in contact with other Joint Commission staff that can assist you.

Notice of Re-Certification Onsite Review
Your organization will receive notice from The Joint Commission seven business days prior to the first day of the scheduled review date(s) for Integrated Care re-certification. The notice will be to the certification contact identified in your application and will include the specific review date(s) and the program(s) being reviewed. A follow-up communication with your organization will confirm the information previously provided. Additionally, **the Notification of Scheduled Events link on your organization's extranet site, The *Joint Commission Connect*, is populated with the review date, reviewer's name, biographical sketch and picture at 7:30 a.m. in your local time zone on the morning of the review.**

Logistics

- While onsite, the reviewers will need workspace for the duration of the visit. A desk or table, telephone, access to an electrical outlet and the internet are desirable.

- Some review activities will require a room or area that will accommodate a group of participants. Group activity participants should be limited, if possible, to key individuals that can provide insight on the topic of discussion. Participant selection is left to the organization's discretion; however, this guide does offer suggestions.

- The reviewers will want to move throughout the clinical care partners' sites during Tracer Activity, talking with staff and observing the day-to-day operations of the organization along the way. The reviewer will rely on organization staff to find locations where discussions can take place that allow for confidentiality and privacy, and that will minimize disruption to areas being visited.

- While reviewers will focus on current patients that are included in the integrated care program, they may request to see some closed records as well in order to verify patient discharge instructions, education and post discharge or visit follow-up.

The sample agenda for the onsite review appears later in this guide and will be posted to your *Joint Commission Connect* extranet site. The review agenda presents a suggested order and duration of activities. Prior to the review date, please discuss the agenda and activities with the Account Executive. When the reviewers arrive, discuss any agenda changes with them at any time during the onsite visit.

Information Needed During On-site Review

The standards require the following information in writing. Reviewers will need to see this documentation to determine compliance with the noted requirements.

1. Hospital(s), ambulatory site(s), home care organizations, behavioral health care organizations, and nursing care centers, the clinical care partners, that form the integrated care program [ICPA.01.01.01, EP 1]
2. Clinical care partners' mutual mission, vision, and goals for the integrated care program [ICPA.01.01.05, EP 1]
3. Integrated care program scope of care, treatment, and services available from its clinical care partners [ICPA.01.01.07, EP 1]

While the standards do not specifically require any additional written information, programs are encouraged to provide reviewers with any available documentation that would demonstrate performance or compliance with the standards requirements.

Required for Tracer Activity Planning

A list of hospital(s), ambulatory site(s), behavioral health care organizations, home care organizations, and nursing care centers included in the integrated care program with the scope of care, treatment, and services available at each, for example:

Site Name, Address, Distance from main or primary review site	Designated Integrated Care Program representative	Care, Treatment and Services Provided
Community Hospital 456 Healthy Drive, Forest, WA 67890 Primary review site	Dr. P. Jones Mr. V. Roberts	General acute care hospital

Community Primary Care Clinic 480 Healthy Drive, Forest, WA 67890 .2 miles from main site	Dr. G. Smith Ms. H. Carter	Primary Care
Community Cardiology Assoc. 235 State St., Forest, WA 67893 10 miles from main site	Dr. N. Thomas Ms. E. Fredrick	Cardiology
Community Cancer Specialists 123 Pine Way, Center, WA 08765 22 miles from main site	Dr. K. Ivy Mr. W. Allen	Oncology
Community Heart Care Clinic 456 Healthy Drive, Forest WA 67890 0 miles from main site	T. Peters APN	Monitoring Program for Patients w Heart Failure
Community Home Care	Ms. J. Curtis, Administrator	Home Health, Personal Care and Support, Home Infusion Therapy
ABC Home Medical Equipment	Mr. A. Howard, Service Manager	Oxygen supplier, durable medical equipment
Rehab to Home Nursing Care Center	Dr. S. Swan, Medical Director	Skilled nursing and rehabilitation center
Catholic Elder Care Community Home	Dr. N. Munson, Medical Director	Life care residence community with infirmary beds

A list containing the type of information displayed in the example above will also satisfy the documentation requirements of standards ICPA.01.01.01, EP 1 and ICPA.01.01.07, EP 1.

Preparing for Patient Tracer Selection -- IMPORTANT

The Tracer Activity Planning Session description found on pages 21-24 of this guide covers:

- Site selection and prioritization for visits,
- Types of ambulatory, home care, behavioral health care organizations, and nursing care center sites the reviewer would like to visit if they are part of the program
- A variety of patient experience scenarios that reviewers are interested in tracing.

Organizations are encouraged to begin identifying sites that fit the selection and prioritization guidance, as well as potential patients for tracer activity at those sites, in advance of the review date. Reviewers will still be involved in the selection of the sites and the specific patients, but it will ease the pressure and burden on staff in trying to find the types of patients that the reviewers want to trace on the spot.

Availability of this information will greatly facilitate the Planning Session allowing the individual tracer activity to proceed in a timely manner.

Reviewer Arrival

Logistics

Duration

10-15 minutes

Participants

- Reception, Security, or Information Desk Staff
- Organization/Program Contact

Procedures

1. Reviewers will arrive at the location identified as the main or primary site between 7:45 and 7:50 a.m.
2. Reviewers will report to the reception area, security officer, information desk, or administrative office upon arrival and provide their name, identification and purpose for their visit.
3. If a program contact is not waiting for the reviewers, they will ask security or reception to phone the program contact. The reviewers wait for an escort unless they are instructed to proceed to another location by the organization/program contact.
4. Reviewers will follow organization visitor procedures as instructed by security or the program contact (e.g., sign in, wear organization visitor identification).
5. While this is an announced visit, reviewers will still confirm that the organization/program contact has been able to access their extranet site and locate information about the review, including
    - Notification of scheduled Joint Commission event authorizing your presence
    - Reviewer name, picture, and biographical sketch
    - Scheduled review date(s)
6. Please inform the reviewers about
    - Working space for the day
    - A secure location where they can place belongings and access them as needed throughout the day
7. Inform the reviewers if there will be a roster of ICC program leaders and staff attending the Opening and Orientation activities or if attendees will sign in. Explain that the roster or sign in sheet is to help you with names of people you have encountered and their roles in the program. You will return it to the program contact at the conclusion of the visit.
8. Plan to leave at least 15 minutes of the opening conference to review the visit agenda and for questions and answers.

Opening Conference

Logistics

Objectives

1. Introductions of program representatives and reviewers
2. Describe the structure of the review
3. Discuss the review agenda, highlighting any changes necessary to facilitate the site visits or increase participation in group activities
4. Answer any open questions about the visit or review process

Duration

30 minutes

Participants

Program administrative and clinical leadership, individual or individuals that will provide the Safety Briefing to the reviewer(s), and others at the discretion of the organization

Other Information

If available, the following items are helpful to the reviewers

- Roster or sign-in sheet of participants
- Organization chart or names of program leadership, titles and roles

Procedures

During

The organization is requested to provide the reviewer(s) with a Safety Briefing (informal, no more than five minutes) sometime during this activity. The purpose of this briefing is to inform the reviewer(s) of any current organization safety or security concerns and how Joint Commission staff should respond if your safety plans are implemented while they are on site. Situations to cover include:

- Fire, smoke, or other emergencies
- Workplace violence events (including active shooter scenarios)
- Any contemporary issues the reviewer may experience during the time they are with you (for example, seasonal weather-related events, anticipated or current civil unrest, or labor action)

The reviewers will

- Provide a brief self-introduction including their background and relevant experience.

- Explain the purpose of the certification review
- Ask organization attendees to introduce themselves
- Describe each component of the review agenda, discuss the plans for tracer activity, including sites that the organization/program has arranged for reviewers to visit, travel logistics and optimal visit times. Make changes to the schedule if necessary.
- Explain that the majority of review activity occurs at the point where care, treatment and services are provided. The term "Individual Tracer" denotes the review method used to evaluate organization/program compliance with standards and validates that there is a commitment to supporting provision of patient-centered, integrated care.
- Remind the program that they want to be as least disruptive to patient care as possible. They will suggest that the program limit the number of staff accompanying them on tracer activity to three or less.
- Give an example of an Individual Tracer for this program, noting that these patient tracers have a different focus.
- Ask the organization about the plans for the **Multi-Disciplinary Group Interview**—when and where it will take place.
- Determine if the program has arranged for a **Patient Group Interview** to occur at some point during the onsite visit. Please identify when and where the visit will take place and note any schedule adjustments that were necessary. If the group interview does not occur, the reviewers will request to talk with as many patients as possible while performing individual tracer activity.
- Ask if there are any questions about the review.
- Answer questions and encourage representatives to ask questions throughout the review.

After

Reviewers will transition into the Orientation to the Program session.

Orientation to Integrated Care Program

Logistics

Objectives

Become familiar with the integrated care program, including:

a. The program's vision, mission, and planning for providing patient-centered, integrated care, treatment and services
b. A high-level view of the integrated care program structure, scope of care, treatment and services (e.g., the physicians, ambulatory clinics, convenient, immediate/urgent care clinics, chronic care clinics, hospitals, home care organizations, behavioral health care organizations, and nursing care centers) and patient populations.
c. The program's assessment of their progress in achieving patient-centered, clinically integrated care among physician and ambulatory providers and the acute care hospital, home care organizations, behavioral health care organizations, and nursing care centers.

Duration

10-15 minutes

Participants

Program administrative and clinical leadership and others at the discretion of the organization

Notes

Materials that may prove useful for this session:

- Organization chart for the program, if available
- List of hospital(s) and ambulatory site(s), home care organizations, behavioral health care organizations, and nursing care centers included in the integrated care program with the scope of care, treatment, and services available at each
- Copies of slides, if the organization is making a formal presentation.
- Program information presented in the organization's application for certification or on their internet web site

Procedures

During

If a presentation is planned, reviewers will ask the presenter to indicate if they would like to take questions, during or at the conclusion.

The organization is asked to provide a high-level overview of their integrated care program in either a 10-15 minute presentation or in discussion with reviewers. The focus should be on the following:

- A brief review of the organization's journey towards providing clinically integrated care
- Vision, mission and planning for patient-centered, integrated care, treatment and services
- **IMPORTANT!** Scope of care, treatment and services included in the integrated care program
- Identify the program's clinical care partners, including:
  - hospitals and ambulatory clinics,
  - primary care and specialty care physicians,
  - medical groups,
  - urgent care,
  - convenient care sites,
  - home care organizations,
  - behavioral health care organizations, and
  - nursing care centers.
- Patient populations that integrated care program covers, highlighting those where evidence will be more apparent
- Program structures and processes that support the provision of patient-centered, clinically integrated care
- Leaders and staff involved in the design, development and operations of the integrated care program
- Current program status, that is, what is currently in place that reviewers will see and hear about from physicians and staff throughout the organization
- Clinical integration related initiatives that are in design, planning, development, and testing phases

After

Reviewers will transition to Care Integration Design and Planning session for a more in-depth discussion of the topics addressed in this orientation.

Care Integration Design and Planning

Logistics

Objectives

1. Learn about the program's vision, mission, and planning for providing patient-centered, integrated care, treatment and services.
2. Become familiar with the integrated care program structure, scope of care, treatment and services (e.g., the physicians, ambulatory clinics, convenient, immediate/urgent care clinics, chronic care clinics, hospitals, home care organizations, behavioral health care organizations, and nursing care centers) and patient populations.
3. Understand the program's design and expectations for the patient-centered, integrated care, treatment and service experience.
4. Assess the program's progress (including self-assessed) in achieving patient-centered, clinically integrated care among physician and ambulatory providers, the acute care hospital, home care organizations, behavioral health care organizations, and nursing care centers.

Duration

45 minutes

Participants

Program administrative and clinical leadership, representatives from hospital, physician groups, and ambulatory sites, and others at the discretion of the program

Procedures

During

- Reviewers will be seeking and noting examples of services and processes that the program has put in place to promote and support clinical integration and patient-centered care to validate implementation during individual tracer activity

- Discussion will build upon the introduction from the previous activity and explore in more depth the subjects addressed under the Topics section below.

Topics

- Program mission, vision, and goals –
    - Development and negotiation process for the mutual program mission, vision, and goals (Note: ICC does not require that each clinical care partner change their organization-specific mission, vision, and goals; instead reviewers will look for

evidence of alignment with the program or determine if they are complementary in nature)
    - Evidence reflecting collaboration and alignment of the clinical care partners
    - People involved in development and continued refinement -- multi-disciplinary, settings represented
    - Reflective of program-defined culture of safety – promote trusting relationships, and appropriate patient care, provided at the right time, in the right setting
    - Awareness of the mission, vision and goals for patient-centered, integrated care among the clinical care partners

- Program design influences – such as, analysis of community needs assessments, census information for service areas, clinic and physician office patient population data, population health priorities, patterns and trends in patient use of health care resources, identified health disparities in patient population
    - Specific examples of how patient population data analysis work influences design of program services and processes
- Other service and process design influences – potential risks to patient population, evidence-based information, performance improvement activities;
- Program structure – evidence that a planned and organized integrated care program exists; hospital, physician/ambulatory sites, home care organizations, behavioral health care organizations, nursing care centers, and others that form the program are identified
- Program identified scope of care, treatment, and services available from its hospital(s) and physicians/ambulatory sites
    - Scope – birth through end-of-life, for its patient population
    - Inclusive of chronic disease management services that follow clinical practice guidelines
    - Identified care, treatment, and services that are available through referral, contract or other means to meet patient needs
    - Criteria and performance expectations used to select referral providers; ask about development process and who was involved; ask about how the selection process works
- Program design and use of interdisciplinary teams—within a given clinical care partner's operations, but also talk about any program efforts for the teams to span the program's continuum of care
- Program relationship to any overarching organization structure (e.g., health care system, multi-hospital system, medical group(s), independent practice association)
- Program leadership and management – determine if membership is inclusive of administration and clinicians, inclusive of clinical care partner representatives
    - Administrative and clinical leaders responsible for integrated care activities at each physician/ambulatory sites, hospitals, home care organizations, behavioral health care organizations, and nursing care centers

- Strategic planning process (who is involved, who/what is influencing strategy and planning, who/what is influencing priorities, is priority setting balanced among clinical care partners
- Patient populations that are noticeably experiencing integrated, patient-centered care and the performance is being monitored and impact on outcomes is the subject of measurement activity
- Integration incentives, influencers
  - Group purchasing/negotiation power
  - Technology planning, affordability, and access (e.g., hospital IT support with equipment purchases, maintenance, security
  - Service availability and accessibility (e.g., centralized scheduling, urgent care or convenient care)
  - Medical specialty resources
  - Access to patient-centered care resources (e.g., interpreter services, translated written materials, care managers, social work)
  - Patient health and self-management education resources
  - Resources to monitor emerging trends
  - Population/community health data
  - Facilitating access to interdisciplinary care, treatment and service needs of patients
- Communication planning and processes –
  - Information provided to physicians/ambulatory sites and hospital(s) regarding the scope of care, treatment, and services available through the integrated care program
  - Information provided to patients about the integrated care program
  - Information provided to patients about the scope of care, treatment, and services available through the program's clinical care partners
- Communication of patient health information
  - Accessibility of patient health information to providers throughout program
  - Accessibility and use of electronic prescribing processes
  - Types of clinical decision support tools in use
  - Communication process -- monitoring and evaluation for effectiveness
- Performance improvement related to patient-centered, integrated care program
  - Patient involvement
  - Focus of priorities and activities
  - Scope of performance improvement activity—that is, does it span the inpatient and outpatient, post-acute care settings
  - Clearly defined clinical, operational, and financial performance goals
  - Program consideration and use of performance measurement work in which clinical care partners are already engaged; exploring options to use this data to reveal integration and patient-centered care trends

Tracer Activity Planning Session

Logistics

Objectives

1. Identify patients to trace that have recently used or will be using the integrated care program's clinical care partners
2. Identify clinical care partners that will be visited and when
3. Plan logistics for clinical care partner visits (e.g., time for visits, transportation)

Duration

30 minutes

Participants

- Integrated Care Certification program contact
- Practice managers, care coordinators, or other representatives familiar with patient population, patient scheduling systems, from primary and specialty ambulatory sites
- Hospital case managers, patient navigators, others responsible for care coordination

Notes

- **Preparing for Patient Tracer Selection – IMPORTANT --** Organizations are encouraged to begin identifying sites that fit the selection and prioritization guidance, as well as potential patients for tracer activity at those sites, in advance of the review date. Reviewers will still be involved in the selection of the sites and the specific patients, but it will ease the pressure and burden on staff in trying to find the types of patients that the reviewers want to trace at the time of the visit.

- Consider patients that are part of chronic disease management programs (CHF, diabetes) as they can often provide opportunities to evaluate transitions between hospital, ambulatory care, home care, behavioral health care organizations, and possibly nursing care centers

- Hospital or Emergency Department patient discharges in the past seven days can be a good source for identifying patients due for ambulatory site appointments – they will be approaching the due date for their first post-hospitalization appointment

- Hospital or ambulatory surgery center discharges to home with planned home care services, or planned behavioral health care, or to a nursing care center for inpatient rehabilitation services

- Consider types of behavioral health care settings the reviewer should visit if they are part of the program.

- Availability of patients for interview should influence tracer selection. Select patients scheduled/confirmed for ambulatory site appointments, hospitalized patients scheduled for discharge home, or to behavioral health care services, home care patients and nursing care center patients recently admitted to the service or close to completing services.

- Calls to ambulatory sites may be required to confirm a patient is scheduled/confirmed for an appointment. Reviewers will request the organization's assistance in planning and making calls to current home care patients.

Procedures

Before

Reviewers will take a few minutes to:

- Confer on the discussions during the first few activities
- Identify what needs follow-up during tracers and other scheduled activities
- Discuss types of patients and sites that will allow for evaluation of program design, processes, and activities intended to promote and facilitate clinical care partner provision of integrated and patient-centered care

During

Reviewers will want to know:

- If the program uses a high-risk (e.g., for readmission, for number of medications or co-morbidities or any other indications) patient identification process; is the process standardized and implemented with all clinical care partners; ask if a report of patients with the status can be produced or is available to any program clinical care partner

- How the program identifies patients to follow for monitoring its own performance relative to clinical integration and provision of patient-centered care

Site Selection and Prioritization

At a minimum, reviewers must be able to visit and trace patients:

- On one hospital unit that is transitioning patients to ambulatory sites; and
- In one ambulatory site (on or off campus) which is receiving patients from, or referring patients to the hospital.
- If home care is a clinical care partner in the program, trace a patient who is being discharged from the hospital to home, with home care services; and trace a patient that is receiving home care services and who is also scheduled for a follow-up appointment with a physician.
- If a nursing care center is a clinical care partner in the program, trace a patient discharged from the hospital to the nursing care center; trace a patient of the nursing care center being admitted to the hospital or being discharged from the nursing care center to home with home care services.

- If a behavioral health care organization is a clinical care partner in the program, trace a patient discharged from the hospital to the behavioral health care organization; trace a patient of the behavioral health care organization being admitted to the hospital.

Additional guidance that reviewers will follow when selecting sites for visiting include:

Hospital Locations

- Conduct tracer activity on at least two inpatient units (e.g., med/surg., cardiac, oncology), new elective and emergent admissions
- Conduct a tracer in the Emergency Department (e.g., discharged from ED to home with scheduled follow-up appointment at ambulatory site)
- Conduct tracers that find patients moving between acute care and the hospital's inpatient rehab or transitional care unit, behavioral health care, or a nursing care center, if applicable
- If time allows and the tracer drives the need, visit some diagnostic testing locations (laboratory, radiology) or therapeutic treatment locations (PT, OT, ST, dialysis, chemo/radiation, wound care, cardiac or pulmonary rehab)

If program includes additional hospital sites, reviewers will visit at least one other hospital and

- Trace patients in locations/services that patients transfer from or transfer to most frequently when moving between hospitals, for example:
    - Patient admitted, requires cardiac cath and service is only available at another program hospital
    - Patient visits ED, evaluated and assessed needs require surgery that is only available at another program hospital
    - Patient visits primary care clinic at closest hospital; needs a diagnostic test which is only available at another program hospital

Ambulatory Sites

Reviewers will trace patients in the following types of ambulatory sites who have transitioned to or from the hospital, or between ambulatory sites

- Primary care medical home, if applicable (at least 1 site)
- Primary care clinics/practices (at least 1-2 sites) [one independent practice, if any, and one hospital owned/operated; or two hospital owned/operated)
- Specialist care clinics/practices (at least 1-2 sites) [criteria same as above]
- Chronic care clinics/practices (at least 1 site) [e.g., CHF clinic, COPD clinic, prenatal care clinic, wound care]
- Immediate care/urgent care/convenient care, if applicable (at least 1 site)

Home Care Organizations

Reviewers will trace patients with orders for a variety of services provided by the organization including:

- Nursing

- Pharmacy
- Personal care and support
- Therapy (physical, respiratory)
- Hospice

Nursing Care Centers

Reviewers will trace patients being admitted to nursing care centers for a variety of diagnoses and conditions and different anticipated lengths of stay, such as

- Patients being discharged from hospital or ambulatory surgery centers to inpatient rehabilitation units or other organizations
- Patients that were admitted from a nursing care center (both emergent and elective) and who are being discharged to the same center or another center

Visiting additional sites and prioritizing the selection of those sites is at the reviewers' discretion and is based on what they learn during the Orientation to the Program and Care Integration Design and Planning discussions.

Behavioral Health Care Organizations

Reviewers will trace patients in behavioral health care organizations who have transitioned to or from the hospital, ambulatory sites, nursing care centers or who may be receiving home care services.

Patient Selection

Reviewers and participants will:

- Discuss the types of patients and sites that will contribute to validating implementation of services and processes that were described in early activities
- Engage in deliberate patient selection to identify the types of situations necessary to evaluate integration of clinical care
  - Include patients from as many populations as possible to which the integrated care program applies, for example: Age groups, payer/insurer, patient race and ethnicity
  - Consider the program's clinical care partners; select patients that will allow tracing across the hospital-ambulatory-post-acute care continuum in as many sites as possible
- Identify as many patients as possible that allow for tracing across settings and closing the loop on the latest patient transition
- Consider the following examples:
  - Patient discharged from hospital or emergency department for follow-up with primary care, both in program and non-program providers
  - Patient discharged from hospital or emergency department for follow-up with specialty care, both in program and non-program providers
  - Patient experiencing a hospital readmission within 30-days of previous discharge

    - Patient with encounter in one ambulatory site and referral to another ambulatory site (e.g., primary care to specialty care; convenient care to primary or specialty care)
    - Ambulatory site patient with planned admission (e.g., elective or emergent surgery)
    - Ambulatory site patient referred to ED for emergent evaluation and admission
    - Patient receiving care coordination, case management, or clinical navigator services from either the hospital or ambulatory sites
    - Hospitalized patient already established and monitored in the ambulatory setting for chronic conditions, multiple co-morbid conditions, disease management (e.g., CHF, COPD, diabetes, asthma) who are at increased risk of acute episodes requiring hospital admissions
    - Hospitalized patient being discharged and newly referred to a program primary care physician or ambulatory setting for continuing care, treatment and services
    - Hospitalized patient being discharged to home by a hospitalist with orders for home care services and follow-up with primary care or specialist
    - Hospitalized patient being discharged by a hospitalist to a nursing care center with follow-up
    - Patient on home care service that is scheduled for an appointment with primary care or specialist
    - Nursing care center patient that is being emergently transferred to the hospital or is an elective admission
    - Nursing care center patient or resident with an ambulatory clinic or office appointment
    - Nursing care center patient that is being discharged home with home care services or outpatient rehabilitation services
    - Behavioral health care patient that is being emergently transferred to the hospital or is an elective admission
    - Behavioral health care patient with an ambulatory clinic or office appointment
    - Behavioral health care patient that is being discharged home with home care services or outpatient rehabilitation services
    - Behavioral health care patient that is being discharged to a nursing care center
- Work together to plan the most efficient schedule for clinical care partner visits, considering:
    - Travel distance, possibility of covering two sites within available tracer time
    - Availability of physicians, staff, and patients for interview during the site visit
    - Other review activities that follow planned site visit time
- Determine plans for transportation to ambulatory sites

After

Begin tracer activity

Individual Tracer Activity

Logistics

Objectives

1. Follow a patient's experience when care, treatment, and services involve transitioning between clinical care partners
2. Validate that the program has processes designed to, and resources available that will enable clinical care integration among partners
3. Assess the implementation of processes designed to facilitate collaboration and coordination among clinicians and across the patient care continuum
4. Determine progress in implementing patient-centered approaches to care, treatment, and services as designed and expected by the program

Duration

Variable per patient tracer conducted; tracing of multiple patients in multiple locations occurs during the blocks of time noted on the agenda

Participants

Reviewers will require an escort during each of the blocks of tracer time. Transportation to various sites will need to be planned as well.

Hospital clinical and administrative staff, ambulatory site clinical and administrative staff, physicians, physician assistants, and nurse practitioners, nurses, social workers, mental health providers, discharge planners, and other clinical staff involved in patient care, treatment and services who have an awareness of and participate in program efforts to integrate clinical care

Procedures

During

- Each reviewer will be tracing patients across the hospital, ambulatory, home care, behavioral health care, and nursing care center segments of the continuum

- Tracer activity focuses on the program's design and implementation of processes that facilitate the integration of patient clinical care across the hospital, ambulatory, home care, behavioral health care, and nursing care center segments of the continuum

- Reviewers will approach tracers with the goal of finding evidence that the last health care transition, encounter, appointment is being followed-up, continued or closed out as the provider intended, as the patient understands, and the program expects

- Reviewers are listening and looking for evidence during tracer activity interviews with physicians, staff, and patients and families of patient-centered care taking place

- Reviewers will observe physicians and staff using the available resources and processes to help them with communication, accessing information, and planning and facilitating patient health care

- Following are some standards-based topics that reviewers will be considering during certain types of patient tracers:

Hospitalized patient discharging to home, that was referred from or returning to Ambulatory site for follow-up

Hospital staff and patient encounter will focus on:

- Patient involvement in developing treatment plan
- Identifying patient health literacy and communication needs
- Patient self-management goals and education on self-management tools and techniques
- Patient education and discharge instructions
- Follow-up appointment scheduling
- Instructions on who to call with questions or in an emergency
- Information exchange with ambulatory provider
- Medication reconciliation

Hospitalized patient referred from Ambulatory site for elective admission or through Emergency Department for emergent care

Hospital staff and patient encounter will focus on:

- Information exchange with hospital
- Transition process including:
  - Outpatient plan for care and progress/status at time of inpatient admission
  - Review of patient history and patient's goals
  - Review of patient health literacy, cultural influences on health, communication strategies
  - Review of potential patient risks with the transition to inpatient care
  - Medication reconciliation
  - Revision of outpatient plan for care based on outcome of inpatient stay or emergency department visit

Patients referred from one ambulatory site to another (e.g., single or multiple medical specialists) for evaluation, care and treatment

Ambulatory site visit will focus on:

- Availability of appointments and ease of scheduling for staff and patients
- Information exchange between providers
- Evidence of verbal transition including:
  - Outpatient plan for care and progress/status at time of referral
  - Review of patient history and patient's goals
  - Review of patient health care literacy, cultural needs
  - Review of potential patient risks, *especially with the introduction of another physician/ambulatory provider*
  - Medication reconciliation
- Updating patient plan of care and goals to reflect the addition of specialty care
- Clarity on provider roles and scope of involvement in care, treatment and services
- Follow through on test results, follow-up on consult reports and recommendations
- Monitoring patient progress towards achieving treatment goals and their personal health goals

Patient recently discharged from the hospital to ambulatory clinic for ongoing monitoring and who is at risk for readmission

Ambulatory site visit will focus on:

- Information exchange with follow-up provider
- Evidence of verbal transition including:
  - Inpatient care plan, progress, and outcome
  - Review of patient history and patient's goals
  - Review of patient health care literacy, cultural needs
  - Review of potential patient risks *especially with the transition to ambulatory care*
  - Medication reconciliation, infection prevention
- Updating patient plan for care and goals to reflect the transition to ambulatory care
- Follow-up with patient to clarify discharge instructions, any problems the patient is experiencing complying with the instructions (e.g., filling prescriptions, making/attending appointments)
- Monitoring patient progress towards achieving treatment goals

Patients referred from one ambulatory site to another (e.g., patient referred for diagnostic testing services or treatments—lab, radiology, specialty clinic such as, pulmonary testing, dialysis, chemotherapy)

Ambulatory site visit will focus on:

- Information exchange between providers
  - Updated plan for care
  - Review of patient-specific information to prepare for receiving the patient and providing care, treatment, and services
  - Review of patient health care literacy, cultural needs
  - Review of potential patient risks
  - Availability of appointments and ease of scheduling
  - Communicating results, both critical and routine to the patient and to providers

Patient recently referred to the ED for emergent evaluation and admission, or patient due for hospital admission for elective care, treatment, and services

Ambulatory site visit will focus on:

- Information exchange with follow-up provider
- Evidence of verbal transition including:
  - Outpatient plan for care and progress/status at time of inpatient admission
  - Review of patient history and patient's goals
  - Review of patient health care literacy, cultural needs
  - Review of potential patient risks with the transition to inpatient care
  - Medication reconciliation, infection prevention
- Updating patient plan of care and goals to reflect the transition to inpatient care
- Monitoring patient progress towards achieving treatment goals

Hospitalized patient referred from behavioral health care organization for emergent care

Hospital staff and patient encounter will focus on:

- Information exchange with hospital
- Transition process including:
  - Discharge plan for care and progress/status at time of inpatient admission
  - Review of patient history and patient's goals
  - Review of patient health literacy, cultural influences on health, communication strategies
  - Review of potential patient risks with the transition to inpatient care
  - Medication reconciliation
  - Revision of behavioral health care plan for care based on outcome of inpatient stay or emergency department visit

Patient being discharged from hospital to a behavioral health care organization with follow-up planned in an Ambulatory site

Hospital tracing activity will focus on:

- Information exchange between physicians – hospitalists and psychiatrist or primary care physician
  - Discharge summary
  - Review of patient history, plan of care and patient's goals based on hospitalization
  - Review of patient health care literacy, cultural and communication needs
  - Plan for behavioral health care services
  - Patient specific information to prepare for receiving the patient and providing care, treatment, and services
  - Medication reconciliation (alert of new or discontinued medications)
  - Infection Prevention, Immunization record
  - Laboratory tests pending
  - Follow up appointments needed (including further testing or treatments needed)
  - Advance Directives, power of attorney information
  - Information and education provided to patient

Patient being discharged from hospital to home with planned home health care services (for example, infusion therapy, nursing services, wound care, personal care and support)

Hospital tracing activity will focus on:

- Information exchange between physicians – hospitalists and primary care or specialist physicians assuming post-hospital care direction and responsibility for working with home care provider
  - Discharge summary
  - Review of patient history, plan of care and patient's goals based on hospitalization
  - Review of patient health care literacy, cultural and communication needs
  - Plan for home health care services and name of home care provider
  - Patient specific information to prepare for receiving the patient and providing care, treatment, and services
  - Medication reconciliation (alert of new or discontinued medications)
  - Infection Prevention, Immunization record
  - Laboratory tests pending
  - Follow up appointments needed (including further testing or treatments needed)
  - Advance Directives, power of attorney information
  - Information and education provided to patient

Home Care organization site visit tracing activity will focus on:

- Information exchange and patient hand-off processes with the discharging hospital
  - Format of hand-off (e.g., phone call, paper or electronic information exchange, home care nurse, attends interdisciplinary team meeting)
  - Name of primary care provider or specialist assuming care for the patient post-discharge
  - Orders and plan for home health care services
  - Review of patient history, plan of care and patient's goals
  - Review of patient health care literacy, cultural and communication needs
  - Patient specific information to prepare for receiving the patient and providing care, treatment, and services
  - Medication reconciliation (alert of new or discontinued medications)
  - Infection Prevention, Immunization record
  - Laboratory tests pending
  - Review of potential patient risk for readmission
  - Follow up appointments needed (including further testing or treatments needed)
  - Advance Directives, power of attorney information
  - Information and education provided to patient

- Interaction between the home care staff and the primary care provider or specialist following the patient post-hospital discharge
  - Availability of provider to receive report and guide the provision of home care services
  - Responsiveness of provider to home care team requests on behalf of the patient
  - Provider reports to home care staff following patient ambulatory visits with provider—test results, change in orders and plan for home health services
  - Means of communication; consistency of processes among program clinical care partners

- Home care interdisciplinary team interaction (when applicable)
  - Information exchange between home health nurse, personal care and support aides/attendants, pharmacist, and therapists that are working with the patient in the home

Additional patient situations to trace/discuss during the Home Care organization site visit

- Patient referred to Home Care organization by ambulatory service provider
- Patient discharged from Nursing Care Center to home with home health care services
- Home Care patient being admitted to hospital or nursing care center

Patients being discharged from hospital to a nursing care center (both a new center admit and a returning center patient)

Hospital tracing activity will focus on:

- Information exchange between physicians
  - Discharge summary
  - Review of patient history, plan of care and patient's goals
  - Review of patient health care literacy, cultural and communication needs
  - Prescriptions needed (opioids)
  - Patient specific information to prepare for receiving the patient and providing care, treatment, and services
  - Medication reconciliation (alert of new or discontinued medications)
  - Infection Prevention, Immunization record
  - Laboratory tests pending
  - Follow up appointments needed (including further testing or treatments needed)
  - Advance Directives, power of attorney information
  - Information and education provided to patient

- Direct communication between hospital and nursing care center (physician to physician, nurse to nurse)
  - Review of potential patient risk for readmission
  - Review of patient history and goals
  - Medication reconciliation, infection prevention
  - Laboratory tests pending
  - Advance Directives
  - Nursing care admitting nurse invited to hospital interdisciplinary team meeting prior to transfer

Nursing care center site visit tracing activity will focus on:

- Information exchange with discharging or receiving hospital, or with ambulatory site seeing a nursing care center patient for episodic care
- Evidence of hand-off including, when applicable to the situation:
  - Discharge summary or ambulatory episode of care summary
  - Review of patient history, plan of care and goals, and any changes
  - Review of patient risk for readmission
  - Review of patient health care literacy, cultural and communication needs

    - Medication reconciliation (alert of new or discontinued medications)
    - Infection prevention, Immunization record
    - Continuance and reinforcement of patient education started in hospital, or at ambulatory site
    - Prescriptions needed (opioids)
    - Patient specific information used to prepare for the patient being received to provide care, treatment and services
    - Advance Directives, power of attorney information
  - Direct communication between nursing care center and hospital or ambulatory site (physician to physician, nurse to physician and physician to nurse, nurse to nurse)
  - Follow up on outstanding hospital or ambulatory performed test results, referral results, and scheduling of follow up appointments

Observe

Reviewers will be looking for:

- Use of electronic prescribing in program hospital and ambulatory site(s), home care, behavioral health care organizations, and nursing care centers
- Availability and use of clinical decision support tools by program clinical care partners
- Use of health information technology, specifically validating that it is:
  - Supporting the program's continuity of care design and expectations
  - Providing documentation to track care, treatment, and services a patient receives in any of the program's clinical care partners
  - Supporting chronic disease management provided by the clinical care partners
  - Supporting and facilitating the provision of preventive care by the clinical care partners
  - Facilitating the exchange of information between clinical care partners within the program
  - Facilitating the monitoring of provider and patient follow-through (e.g., appointments being kept, consult reports and test results being received, acknowledged, and acted upon)
  - Supporting program's performance improvement activities
- Use of electronic health record features – are they being used consistently and in a manner that supports collaboration and patient-centered care

Topics

Clinical Care Partner Administration Interviews

Discuss the following topics with partner leader(s):

- Partner's representative to the integrated care program leadership
- Involvement in program strategy, priority setting, resource evaluation
- Program's goals for clinical integration

- Program’s culture of safety
- Program’s clinical and operational performance goals
- Program monitoring and evaluation of communication and other processes designed to facilitate integration of clinical care, treatment and services
- Program benefits, successes and opportunities for improvement

Reviewer interviews with staff during patient tracer activity will focus on:

Physicians, Nurse Practitioners, Physician Assistants, Clinical Staff Interviews

- Electronic prescribing
- Electronic health records
- Availability of patient plan of care throughout the program
- Availability of needed information for patient care, treatment and services
- Clinical decision support tools
- Interdisciplinary team-based care within and across program clinical care partners
- Patient involvement in treatment plan development and goal identification
- Approaches to encouraging patient self-management
- Patient and family health literacy
- Follow-up on orders, consults, test results both within the program and when the patient is referred to a provider outside of the program
- Patient transitions of care – program management or processes to facilitate patient access
- Communication processes related to patient transitions – program expectations for hand-offs (format, information exchange, responsibility)
- Management of conflicts regarding patient care, treatment, and services

Patient Interview

During patient interviews, reviewers will be asking questions such as those found in the following examples:

- Did someone from the organization inform you about the way they are organizing and collaborating to provide you with the best care?
- Did they inform you about the level of service and attention you should expect to receive (convenient appointment scheduling, assistance with scheduling appointments if needed, access to test results and reports)?
- Did you receive any information about the doctors and nurses that are available to provide your care?

- Did someone talk to you about the care, treatment and services that are available to you through this organization? Do they inform you if your care might require you to see another doctor at another hospital?
- Were you given any information about availability and access to services should you have an emergency or an urgent need?
- What information or instructions did you receive about:
  - Making an appointment with your doctor or clinic,
  - Obtaining a prescription refill,
  - Learning the results of any tests you may have had?
- Can you get appointments with the doctor, nurse, or for tests and treatments that are flexible and meet your needs?
- Do you find that the people providing your care know something about you when you arrive and why you are seeing them? For example:
  - Doctors and other staff have information about you so you don't need to complete additional paperwork or answer the same questions over and over
  - They are aware of your needs and goals
  - They know you need assistance with walking or a wheelchair
  - They know that your family member helps you with interpretation and remembering instructions
  - They know about your allergies and your medications

Multi-Disciplinary Group Interview

Logistics

Objectives

1. Learn how clinical integration and patient-centered care manifests on the front-line
2. Learn about the influence and involvement direct care providers have on the program design and implementation
3. Learn how the program's mission, vision, and goals for integrated care are influencing performance of direct care providers

Duration

60 minutes

Participants

This could be an already established group or committee of representatives that lead or guide clinical activities and priorities of the integrated care program.

Integrated care program participating primary care physicians, physician assistants and nurse practitioners, contract physician services, hospitalists, intensivists, and physician specialists, case managers, patient navigators, or others responsible for helping patients through the healthcare system; social work, child-life specialists, medical group practice managers, ambulatory clinic managers.

Procedures

Before

Reviewers will reflect on tracer activity discussions with individual physicians and staff in clinical care partner sites to identify topics for this discussion. Examples of the types of observations they would follow-up on in this group discussion include:

- Information not being available when they needed it in order to provide the best care for the patient
- Difficulty using some process or lack of clarity in a procedure that was making their work more complicated than necessary
- Concerns that patients expressed to them about the care, treatment and service experience within the program
- Missed opportunities or unsuccessful attempts to collaborate and coordinate with other providers on patient care

During

Reviewers will:

- Explore the subjects presented in the Topics section below with participants
- Ask participants to provide specific examples, if possible, of successful multi-disciplinary group care that crossed the clinical care partner continuum
- Ask participants to describe some patient situations that could have benefited from a multi-disciplinary approach to care

Topics

- Processes supporting clinical integration (e.g., information sharing, hand-offs between providers and settings, facilitating patient transitions)
- Influence of different disciplines on the overall program design
- Role of the multi-disciplinary group – if this is an established group explore
    - Composition (what disciplines, what sites)
    - Purpose of the group
    - Influence on patient care process design and program-wide decisions
    - Influence on performance improvement priorities
    - Influence on communication strategies
- If this is not an established group that the reviewer is speaking with, they will ask how the program provides opportunities for individuals like them to influence program structures and processes
- Patient-centric interdisciplinary team composition and planning
    - Is cross-setting interdisciplinary team a possibility
- Coordination and collaboration between settings, services and care providers
- Patient and family participation in treatment planning
- Patient and family access to the team, to ambulatory services

Reviewer Team Meeting and Planning

Logistics

Duration

30 minutes

Participants

Program contact or staff, if requested by the reviewers

Procedures

During

Reviewers will:

- Discuss their observations and what they have learned
- Look for similar observations and identify patterns and trends
- Think about and review/discuss connections between observations and standards
- Discuss and plan their approach to review activities for the next day
- Establish areas of focus for subsequent tracer activity
- Identify topics for further discussion during upcoming activities
- Prepare for the Daily Briefing discussion with the organization

Daily Briefing

Logistics

Objectives

1. Provide organization representatives with a brief summary of survey activities of the previous day.
2. Relay observations and note examples of strengths and possible vulnerabilities in performance.

Duration

30 minutes

Participants

- Program administrative and clinical leaders
- Others at the discretion of the program

Procedures

During

Reviewers will:

- Briefly summarize review activities completed on the previous day. Discuss at a high-level some of the patterns and trends they are seeing.
- Ask the program representatives to clarify or help them understand what they have been hearing and observing.
- Answer questions and clarify comments when requested.
- Review the agenda for the day.
- Make necessary adjustments to plans based on program needs or the need for more intensive assessment
- Confirm logistics for the day, sites that will be visited, transportation arrangements, and meeting times and locations for any group activities
- Reviewers may ask to extend the Daily Briefing if necessary. However, they will be considerate of staff time. They will **not** make all program representatives stay for a discussion that is specific to a small group of individuals.

Patient Group Interview

Logistics

Objectives

1. Gather feedback from the group intended to experience the benefits of patient-centered, integrated care.
2. Learn about the program/organization integration efforts from the patient's point of view.
3. Determine if the program/organization gives patients enough opportunity to provide feedback
4. Determine if the organization uses the patient feedback to prioritize and improve performance.

Duration

50-60 minutes

Participants

This could be an established patient group or a gathering of patients who are members of other organization committees, such as:

- Patients who are part of a support group
- Patients scheduled for monitoring and education group appointments
- Patient relations committee members
- Representatives of a volunteer program who have been a patient or supported a family member who has been a patient
- Patient advisory committee
- Any other organized patient and family groups who use the services of the clinical care partner sites.

Notes

If it is not possible to convene a group of patients for this interview, reviewers will continue with individual tracer activity

A flyer describing the certification program and this activity along with examples of discussion questions appears at the back of this guide. It may be useful to the program when seeking out patients or family members to participate in this interview.

Procedures

Before

Reviewers will:

- Consider what they have learned during individual tracer interviews with patients

- Determine subjects that they would like to pursue in more depth with patients
- Plan an approach to keep the discussion focused

During

Program staff attendance during this activity is left to the program and reviewer judgement.

- If patients seem comfortable talking with program staff present, this might be an indicator that they should attend this group activity as well and hear directly from the patients. If program representatives do attend, they are asked to listen or clarify, but not engage in the interview.
- If patients seem to be holding back, or tentative in speaking up when program representatives are present during individual tracer activity, then perhaps the program representatives can remain nearby but not in the room during this activity. Reviewers will share a compilation of patient feedback.
- Reviewers will avoid health care jargon. They will have some examples that will help patients understand what they are asking.

Topics

Reviewers will explore some of the following topics with the group:

- What type of information does the organization share with you about it's doctors, hospital, nurses, and staff?
- Do you receive all of your health care through this organization?
- Describe your experiences moving between clinical care partners (doctor visit, specialty clinic visit) or between doctors.
    - What was your impression of the experience? Did you have any concerns? Were these addressed to your satisfaction?
- Does the access you have to doctors or your other care team members meet your needs? (e.g., appointment days and times, hours of operation, patient portal messaging, email)
- When you have questions related to medications, or need to clarify instructions you received or concerns about your health and treatment, whom do you call?
- How do you communicate with your doctor or other care team members (phone, email, text, patient portal)?
- Have you been involved in planning your care and treatment? How? What does the doctor or care team expect of you?
- Does the doctor or team planning your care and treatment ask about your goals and what is important to you? Do you see your goals reflected in their plans?

Program Performance Improvement

Logistics

Objectives

1. Learn how the program is measuring the design and implementation of its integrated care program across settings
2. Learn how the program is using data to evaluate the safety and quality of care being provided to patients
3. Understand and assess the program's performance improvement process

Duration

60 minutes

Participants

- Program administrative and clinical leaders
- Representatives of clinical care partner sites involved in program performance improvement, (e.g., guidance, priority setting and implementation)
- Others at the discretion of the program

Procedures

During

Reviewers will:

- Listen for how the program/organization is leveraging the measurement work already underway to help inform integrated care program performance
- Listen and look for evidence of clinical care partner sites collaborative planning and priority setting around measuring integrated care program performance
- Listen and look for measurement activity that spans the clinical care partner sites
- Learn about who is involved and what drives priority-setting decisions for performance measurement and improvement
- Engage program staff in a discussion of the subjects noted under the Topics section.

Topics

- Integrated care program's priorities for performance improvement
- Work underway to measure performance across health care settings

- Outcomes of interest to both employed and community physicians
- Outcomes of interest to other ambulatory care sites
- Performance measurement already taking place that relates to patient-centered, integrated care program efforts
- Patient satisfaction data
- Physician and care team member performance information needs
- Monitoring effectiveness of processes and services intended to foster collaboration and communication around patient care and treatment

Reviewer Report Preparation

Logistics

Objectives

1. Complete the entry of observations made throughout the survey

2. Prepare an event summary to share with the program

Duration

60 minutes

Participants

Program participation is not required

Procedures

Upon completing their work, reviewers will:

- Make arrangements with the program representatives to print and copy the report for:
  - The organization, if it is being distributed to Exit Conference participants
  - Each reviewer

- Inform the program contact that they are ready to proceed with the Exit Conference

Exit Conference

Logistics

Objectives

1. Present the Summary of Certification Review Findings Report (only if desired by the CEO)
2. Review identified standards compliance issues and note that all findings of less than full compliance require resolution through an Evidence of Standards Compliance submission
3. Review required follow-up actions

Duration

30 minutes

Participants

- Program and clinical leaders
- Other staff at the discretion of the organization

Procedures

During

The reviewers will share a report of their onsite experience and observations. They will highlight strengths and progress and will note any potential areas of vulnerability and how these relate to the standards and what the program will see reflected in the Summary of Certification Review Findings. Reviewers will not go through the report item by item with the group assembled for the Exit Conference. If the organization desires this level of report discussion, it is recommended that it occur with just a small number of program representatives.

Sample Agenda

Integrated Care Certification

<table>
<tr><th rowspan="2">Time</th><th colspan="2">DAY 1 - Activity</th><th rowspan="2">Organization Participants</th></tr>
<tr><th>Reviewer 1</th><th>Reviewer 2</th></tr>
<tr><td>8:00 – 8:30</td><td colspan="2">Opening Conference
• Introductions
• Overview of certification program (reviewers)
• Review organization’s goals and expectations for the on-site visit (organization)
• Review visit agenda and logistics (e.g., sites included in visit, travel to sites, timing of group meetings)</td><td></td></tr>
<tr><td>8:30 – 8:45</td><td colspan="2">Orientation to Organization’s Integrated Care Program

The organization is asked to provide a high-level overview of their integrated care program in either a 10-15 minutes presentation or in discussion that focuses on the following:
• Vision and planning for patient-centered, integrated care, treatment and services
• IMPORTANT! Scope of care, treatment and services included in the integrated care program; identify the specific hospitals and ambulatory clinics, primary care and specialty care physicians, medical groups, urgent care, convenient care sites, home care, behavioral health care organizations, and nursing care centers that are included in the program for purposes of the certification review and why. Also, be prepared to identify those entities excluded from the review, if any, and why.
• Patient populations that integrated care program covers
• Program structures and processes that support the provision of patient-centered, clinically integrated care
• Leaders and staff involved in the design, development and operations of the integrated care program
• Current program status, that is, what is currently in place that reviewers will see and hear about from staff throughout the organization’s integrated care program
• Clinical integration related initiatives that are in design, planning, development, and testing phases</td><td></td></tr>
</table>

Time	DAY 1 - Activity		Organization Participants
	Reviewer 1	**Reviewer 2**	

8:45 – 9:30	**Care Integration Design and Planning**
	
	Discussion will build upon the introduction from the previous activity and explore in more depth the following topics:
	
	• Strategic planning process
	• Program leadership
	• Clinical care partner alignment efforts
	• Program design influences (e.g., community needs assessments, clinic and physician office patient population, patient population risks and outcomes, evidence-based information)
	• Integration incentives, influencers
	  ▪ Group purchasing/negotiation power
	  ▪ Technology planning, affordability, and access (e.g., hospital IT support with equipment purchases, maintenance, security
	  ▪ Service availability and accessibility (e.g., centralized scheduling, urgent care or convenient care)
	  ▪ Medical specialty resources
	  ▪ Access to patient-centered care resources (e.g., interpreter services, translated written materials)
	  ▪ Patient health and self-management education resources
	  ▪ Resources to monitor emerging trends
	  ▪ Population/community health data
	  ▪ Facilitating access to interdisciplinary care, treatment and service needs of patients
	  • Communication planning and processes
	  • Performance improvement related to patient-centered, integrated care program
	    ▪ Patient involvement
	    ▪ Focus of priorities and activities
	    ▪ Scope of performance improvement activity—that is, does it span the inpatient and outpatient setting		

9:30 – 10:00	**Tracer Activity Planning Session**		
10:00 – 12:30 Includes travel time	**Individual Tracer Activity**	**Individual Tracer Activity**	
12:30 – 1:00	Lunch		
1:00 – 3:00 Includes travel time	**Individual Tracer Activity**	**Individual Tracer Activity**	

<table>
<tr><th rowspan="2">Time</th><th colspan="2">DAY 1 - Activity</th><th rowspan="2">Organization Participants</th></tr>
<tr><th>Reviewer 1</th><th>Reviewer 2</th></tr>
<tr><td>3:00 – 4:00</td><td colspan="2">Multi-Disciplinary (Interdisciplinary) Group Interview
(Note: This could be an already established group or committee of representatives that lead or guide clinical activities and priorities of the integrated care program.)

Discussion will focus on how clinical integration manifests on the front-line. Reviewers and participants will explore
Processes supporting clinical integration (e.g., information sharing, hand-offs between providers and settings, facilitating patient transitions)
Role of the multi-disciplinary group
Patient-centric interdisciplinary team composition and planning
Coordination and collaboration between settings, services and care providers
Influence of different disciplines on the program design
Patient and family participation in treatment planning
Patient and family access to the team, to ambulatory services</td><td></td></tr>
<tr><td>4:00 – 4:30</td><td colspan="2">Reviewer Team Meeting / Planning Session</td><td></td></tr>
</table>

<table>
<tr><th rowspan="2">Time</th><th colspan="2">DAY 2 - Activity</th><th rowspan="2">Organization Participants</th></tr>
<tr><th>Reviewer 1</th><th>Reviewer 2</th></tr>
<tr><td>8:00 – 8:30</td><td colspan="2">Daily Briefing</td><td></td></tr>
<tr><td>8:30 – 11:00
Includes travel time</td><td>Individual Tracer Activity</td><td>Individual Tracer Activity</td><td></td></tr>
<tr><td>11:00 – 12:00

Note: The review team may decide that only one reviewer will conduct this activity if they are in need of more individual tracer activity time. Reviewers will plan agenda changes with the organization.</td><td colspan="2">Patient Group Interview
(If possible; or reviewers will continue tracer activity)

Note: This could be an established group or patient members of other organization committees, such as: patients who are part of a support group, patients scheduled for monitoring and education group appointments, patient relations committee members, patient advisory committee, or any other organized patient and family groups.

Discussion topics include:
Describe your experiences moving between hospital, ambulatory care (doctor visit, specialty clinic visit), home care, behavioral health care, and nursing care centers. Did you have any concerns?
Does the access you have to doctors or your other care team members meet your needs?
When you have questions related to medications, or need to clarify instructions you received or concerns about your health and treatment, whom do you call?
How do you communicate with your doctor or other care team members (phone, email, text, patient portal)?
Have you been involved in planning your care and treatment? How? What does the doctor or care team expect of you?</td><td></td></tr>
<tr><td>12:00 – 12:30</td><td>Lunch</td><td>Lunch</td><td></td></tr>
<tr><td>12:30 – 2:00
Includes travel time</td><td>Individual Tracer Activity</td><td>Individual Tracer Activity</td><td></td></tr>
</table>

<table>
<tr><th rowspan="2">Time</th><th colspan="2">DAY 2 - Activity</th><th rowspan="2">Organization Participants</th></tr>
<tr><th>Reviewer 1</th><th>Reviewer 2</th></tr>
<tr><td>2:00 - 3:00

Note: The review team may decide that only one reviewer will conduct this activity if they are in need of more individual tracer activity time. Reviewers will plan agenda changes with the organization.</td><td colspan="2">Program Performance Improvement

Discussion with program representatives will include topics such as:

• Integrated care program’s priorities for performance improvement
• Efforts to measure performance across health care settings
• Outcomes of interest to employed and community physicians
• Outcomes of interest to other clinical care partners
• Performance measurement already taking place that relates to patient-centered, integrated care program efforts
• Patient satisfaction data
• Physician and care team member performance information needs</td><td></td></tr>
<tr><td>3:00 – 4:00</td><td colspan="2">Reviewer Report Preparation</td><td></td></tr>
<tr><td>4:00 – 4:30</td><td colspan="2">Exit Conference</td><td></td></tr>
</table>

Patient Participation Invitation
Integrated Care Certification

Date:
Time:
Place:
Contact:

What is Integrated Care Certification and why is our organization seeking this recognition?

Our organization is voluntarily seeking Joint Commission Integrated Care Certification to learn how well we provide health care, collaborate among facilities, and communicate with patients and families through a patient-centered approach. This evaluation focuses on the coordination efforts of a group of organizations, doctors, and other clinicians who have committed to working together to provide you with safe and effective health care.

The Joint Commission is an organization that accredits and certifies more than 20,500 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. To learn more about The Joint Commission, visit their web site at www.jointcommission.org.

Why does The Joint Commission reviewer want to talk to patients?

- To gather feedback from the people who experience the benefits of patient-centered, coordinated care provided by our health care organizations, doctors and other clinicians.
- To determine if our organization gives patients enough opportunity to provide feedback and make suggestions on how we can improve.

What should patients be prepared to talk about with The Joint Commission reviewer?

Reviewers want to talk with patients about:

- The information our organization shares with you about its doctors, hospital, nurses, and staff
- Where you receive your health care, through our organization, as well as other places
- Access to your doctors or your other care team members and how you communicate with these providers
- Who you talk to when you have questions related to your medications or other health care concerns
- How the doctor and other care team members involve you in planning your care and treatment
- Your experiences moving between our hospital, clinics, and doctors