

Attachment 4
Patient-Centered Medical Home Standards

Core Competency 1: Facilitate ongoing patient relationship with ~~physician-in-a physician-directed team. a primary care practice team.~~

1. Practice utilizes written plan for patient communication including accommodations for hearing and visually-impaired individuals and English as a second language patients.
2. Practice utilizes written materials for patients that explain the features and essential information related to the medical home; materials are published in primary language(s) of the community.
3. Practice utilizes patient-centered care planning (includes patient's goals, values, and priorities) to engage patients in their care. Practice plan can include a written after visit summary outlining future care plan and given to patient at every visit.
4. Practice utilizes reminder/notification system for health care services such as appointments, preventive care, preparation information for upcoming visits, follow-up with patients regarding periodic tests or screening, and for missed appointments.
5. Practice provides patient education and self-management tools and support for patients, families, and caregivers.
6. ~~Practice utilizes medical home team that provides team-based care composed of, but not limited to, the primary care physician(s), care coordinator, and office staff with a structure that values separate but collaborative functions and responsibilities of all members from clerical staff to physician.~~ Practice utilizes medical home team that provides team-based care composed of, but not limited to, the primary care provider(s), care coordinator, and office staff with a structure that values separate but collaborative functions and responsibilities of all members from clerical staff to physician.
7. Practice creates and uses a written plan for the implementation of the medical home including a description of work flow for team members.

Core Competency 2: Coordinate continuous patient-centered care across the health care system.

1. Practice utilizes written protocol with hospital(s) outlining referral and follow-up care coordination, and admission and discharge notifications.
2. Practice provides care coordination and supports family participation in care including providing connections to community resources.
3. Practice utilizes a system to maintain and review a list of patient's medications.
4. Practice team tracks diagnostic tests and provides written and verbal follow-up on results with patient, plus follows up after referrals, specialist care, and other consultations.

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5. Practice utilizes a patient registry.

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6. Practice team defines and identifies high-risk patients in the practice who will benefit from care planning and provides a care plan to these individuals.
7. Practice team provides and coordinates Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.
8. Practice team provides transitional care plan for patients transferring to another physician or medical provider.
9. Clinical data is organized in a paper or electronic format for each individual patient.
10. Practice utilizes a system to organize and track and improve the care of high risk and special needs patients.

Core Competency 3: Provide for patient accessibility to the services of the medical home.

1. Patient has on-call access to the medical home team 24 hours/day, 7 days/week.
2. Practice offers appointments outside traditional business hours of Monday – Friday, 9 a.m. to 5 p.m.
3. Practice utilizes a system to respond promptly to prescription refill requests and other patient inquiries.
4. Practice provides day-of-call appointments.
5. Practice utilizes written practice standards for patient access.

Core Competency 4: Foster efficiency of care by reducing unnecessary health care spending, reducing waste, and improving cost-effective use of health care services.

1. Practice implements interventions to reduce unnecessary care or preventable utilization that increases cost without improving health.
2. Practice establishes at least 2 out of 3 of the following waste reduction initiatives: generic medication utilization, reducing avoidable ER visits or reducing hospital readmissions.

Core Competency 5: Engage in a quality improvement process with a focus on patient experience, patient health, and cost-effectiveness of services.

1. Practice has established a quality improvement team that, at a minimum, includes one or more clinicians who deliver services within the medical home;

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one or more care coordinators; one or more patient representatives; and if a clinic, one or more representatives from administration/management.

2. Practice develops a formal plan to measure effectiveness of care management.
3. Practice develops an operational quality improvement plan for the practice with at least one focus area.
4. Practice utilizes a patient survey to assess their experience of care and sets a schedule for utilization (may be developed or provided by the MCO).
5. Practice identifies one or more patient health outcomes to improve through a clinical quality improvement program using evidence-based guidelines.