Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid and Long-Term Care
Medical Home Standards
Verification and Validation: Tier 1

Tier 1 - Required Minimum Standards

Name of Practice

Key: 1 = Meets standard minimally 2 = Meets standard 3 = Exceeds standard

Core Competency 1: Facilitate an ongoing patient relationship with physician in a physician-directed team.

Standard	
1.1 Utilize a written plan for patient communication including accommodation for patients who have a hearing or visual impairment or for patients whose second language is English (ESL). *Documentation: Copy of the practice's written plan for patient communication.*	Score: ○ 1 ○ 2 ○ 3
1.2 Utilize written materials for patients to explain the features and essential information related to the Medical Home and published in primary language(s) of the community. *Documentation*: Sample of the practice's written materials for patients (ex. brochure, patient handbook, letter of explanation, etc.)	Score: ○ 1 ○ 2 ○ 3
1.3 Utilize patient-centered care planning (including patient's goals, values and priorities) to engage patients in their care. The Medical Home plan may include a written "After Visit Summary" outlining future care plan that is given to a patient at every visit. *Documentation: Sample of the practice's patient-centered treatment plan including information like patient's goals, diagnosis, current medications, patient's symptoms requiring follow-up home instructions for patient, referrals, etc.*	Score: ○ 1 ○ 2 ○ 3
1.4 Utilize reminder/notification system for health care services such as, appointments, preventive care, and preparation information for upcoming visits; follow up with patients regarding periodic tests or screening; and when planned appointments have been missed. *Documentation:* *1. Copy of the policy for reminder/notification system including follow-up for missed appointments; and* *2. Copy of a patient's record noting reminder/notification and/or* *3. Copy of electronic report of notices sent.*	Score: ○ 1 ○ 2 ○ 3
1.5 Provide patient education and self-management tools and support to patients, families, and caregivers. *Documentation: Sample of the practice's patient-centered written materials for patients, families, and caregivers (ex. patient booklet, brochure, screen shot of practice web site, etc.)*	Score: ○ 1 ○ 2 ○ 3
1.6 Utilize a 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. *Definition of Medical Home team: All staff that have contact with the patient. *Documentation:* *1. Organization chart of Medical Home team* *2. Job descriptions for each team member*	Score: ○ 1 ○ 2 ○ 3
1.7 Create and use a written action plan for the implementation of the Medical Home including a description of work flow for team members. *Documentation: Copy of the written plan for implementation of the medical home concept including a description of work flow.*	Score: ○ 1 ○ 2 ○ 3

COMMENTS:

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

Standard	
2.1 Utilize written protocol with hospital(s) outlining referral and follow-up care coordination, and admission and discharge notifications. *Documentation: Copy of the written protocol with hospital(s).*	Score: ○ 1 ○ 2 ○ 3
2.2 Provide care coordination and supports family participation in care including providing connections to community resources. *Documentation*: Copy of a patient's record showing *documentation* of the family participation, if applicable, and connections to community resources.	Score: ○ 1 ○ 2 ○ 3
2.3 Utilize a system to maintain and review a list of patient's medications. *Documentation:* *1. Written explanation of the system used to maintain and review patient's medications; and* *2. Copy of a patient's record showing list of medications*	Score: ○ 1 ○ 2 ○ 3
2.4 Track diagnostic tests and provide written and verbal follow-up on results with the patient plus follows up after referrals, specialist care and other consultations. *Documentation:* *1. If in writing, copy of a written follow-up sent to a patient; and/or* *2. If verbal, copy of a patient's record documenting verbal follow-up.*	Score: ○ 1 ○ 2 ○ 3
2.5 Utilize a patient registry. *Documentation: Screen shot of patient registry showing patient information.*	Score: ○ 1 ○ 2 ○ 3
2.6 Define and identify high-risk patients in the Medical Home who will benefit from care planning and provide a care plan to these individuals. *Documentation:* *1. Written definition of high-risk patients; and* *2. Written explanation of how high-risk patients are identified; and* *3. Copy of a care plan provided to a patient.*	Score: ○ 1 ○ 2 ○ 3
2.7 Provide and coordinate Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) services. *Documentation:* *1. Written explanation of how eligible children are identified and the notification process; and* *2. Copy of a patient's record showing EPSDT services provided or a checklist for a patient showing EPSDT components provided.*	Score: ○ 1 ○ 2 ○ 3
2.8 Provide transitional care plan for patients transferring to another physician or medical home. *Documentation: Written explanation of the practice's transitional care plan with examples of any materials used such as a checklist, letter, documentation of phone calls, etc.*	Score: ○ 1 ○ 2 ○ 3

2.9 Organize clinical data in a paper or electronic format for each individual patient. *Documentation: Copy of blank patient's record showing how an individual's clinical data is organized in a patient specific charting system.*	Score: ○ 1 ○ 2 ○ 3
2.10 Utilize a system to organize and track and improve the care of high risk and special needs patients. *Documentation:* *1. Written explanation of the system used to organize and track the care; or* *2. Copy of patient's record showing documentation of tracking.*	Score: ○ 1 ○ 2 ○ 3

COMMENTS:

Core Competency 3: Provide for patient accessibility to the services of the Medical Home.

Standard	
3.1 Provide on-call access* for patients to the Medical Home team 24 hours/day, 7 days/week. *Definition of On-call Access: At a minimum, clinical advice is available by telephone directly with a licensed heath care professional representing the Medical Home team. *Documentation: Copy of written protocol for on-call access.*	Score: ○ 1 ○ 2 ○ 3
3.2 Offer appointments outside traditional business hours of Monday – Friday 9 a.m. to 5 p.m. *Documentation*: Written explanation of appointment hours outside of 9 a.m. to 5 p.m.	Score: ○ 1 ○ 2 ○ 3
3.3 Utilize a system to respond promptly to prescription refill requests and other patient inquiries. *Documentation:* *1. Written explanation of the system for prescription refills and other patient inquiries including staff responsibilities; and* *2. Copy of a patient's record documenting patient inquiry and response; and* *3. Copy of a patient's record documenting prescription refill or electronic report if using e-prescribing*	Score: ○ 1 ○ 2 ○ 3
3.4 Provide day-of-call appointments. *Documentation: Ten documented patient situations where patient was provided day-of-call appointment.*	Score: ○ 1 ○ 2 ○ 3
3.5 Utilize written Medical Home standards for patient access. *Documentation: Copy of the standards set by the Medical Home practice for patient access (ex. use of phone calls, e-mails, staff on-call, visits to nursing home patients, etc.)*	Score: ○ 1 ○ 2 ○ 3

COMMENTS:

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

Standard	
4.1 Establish at least two out of three of these specific waste reduction initiatives: generic medication utilization, reducing avoidable ER visits or reducing hospital readmissions. *Documentation*: Written explanation of two initiatives chosen and how they will be implemented including patient engagement, staff responsibilities, and plan for monitoring.	Score: ○ 1 ○ 2 ○ 3
4.2 Implement an intervention* to reduce unnecessary care or preventable utilization that increases cost without improving health. *Example of intervention: reduction of unnecessary imaging studies, excessive office visits, utilizing nutrition counseling vs. drug treatment, etc. *Documentation: Written explanation of the intervention selected and how it will be implemented.*	Score: ○ 1 ○ 2 ○ 3

COMMENTS:

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

Standard	
5.1 Establish a quality improvement team that, at a minimum, includes one or more medical staff who deliver services within the medical home; one or more care coordinators, and if a clinic, one or more representatives from administration/ management, with input for the team from a patient advisory group. *Documentation:* *1. Written description of the Quality Improvement team including who is on the team, goals of the team, and planned frequency of meetings; and* *2. Copy (ies) of meeting notes.*	Score: ○ 1 ○ 2 ○ 3
5.2 Develop a formal plan to measure effectiveness of care management. *Documentation: Copy of the plan to measure effectiveness of care management including planned data sources.*	Score: ○ 1 ○ 2 ○ 3

5.3 Develop an operational quality improvement plan for the Medical Home with at least one focus area. *Documentation: Copy of the plan to improve the quality of the operations of the practice. (Example of focus areas: work flow, fiscal efficiencies, internal communication process, etc)*	Score: ○ 1 ○ 2 ○ 3
5.4 Utilize a patient survey on their experience of care and sets a schedule for utilization. (May be developed or provided through technical assistance.) *Documentation:* *1. Written explanation of how patient survey will be conducted including planned schedule and how information will be compiled; and* *2. Copy of patient survey tool.*	Score: ○ 1 ○ 2 ○ 3
5.5 Identify one or more patient health outcomes to improve through a clinical quality improvement program using evidence-based guidelines. *Documentation: Written explanation of outcomes chosen and what evidence-based guidelines will be used. (Outcome examples: diabetes, asthma, CHF, COPD, etc.)*	Score: ○ 1 ○ 2 ○ 3

COMMENTS:

I certify that all of the Tier 1 Minimum Standards have been met to our satisfaction.

TransforMED Representative Signature	Title	Date

I have reviewed the *documentation* provided and validate that all Minimum Standards have been met to be recognized as a Patient-Centered Medical Home for the Medicaid Medical Home Pilot.

DHHS Representative Signature	Title	Date