

Tier 2 - Optional Advanced Medical Home Standards

Name of Practice

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

Standard	
<p>6.1 Offer patient education and self-management tools and support* to patients, families and caregivers through the Medical Home and/or coordination of community resources.</p> <p><i>*Example of services: group appointments, diabetes education classes in the office or through a community resource, nutrition counseling, weight management classes, etc.</i></p> <p><i>Example of a self-management tool: home asthma action plan.</i></p> <p><i>Documentation: Written description for five patients that have been involved in patient education, use of self-management tools, or have been referred to community resources. Description for each patient should include (a) need as identified by the patient; (b) types of education, self management tools, support, and/or resources provided and by whom; and (c) assessment of the results.</i></p>	<p>Score:</p> <p><input type="radio"/> 1</p> <p><input type="radio"/> 2</p> <p><input type="radio"/> 3</p>
<p>6.2 Utilize a system to monitor drug usage, drug interaction and effectiveness of a patient's medications.</p> <p><i>Documentation:</i></p> <ol style="list-style-type: none"> 1. <i>Written explanation of the system utilized to include medications prescribed; medications filled; follow-up on usage; patient satisfaction; and results; and</i> 2. <i>Copy of ten patients' records showing documentation of monitoring process.</i> 	<p>Score:</p> <p><input type="radio"/> 1</p> <p><input type="radio"/> 2</p> <p><input type="radio"/> 3</p>
<p>6.3 Offer end-of-life planning or counseling to patients who may benefit from these services.</p> <p><i>Documentation:</i></p> <ol style="list-style-type: none"> 1. <i>Written explanation of end-of-life planning or counseling provided; and</i> 2. <i>Five patient scenarios that include the patient's situation, how the service was provided (ex one-to-one counseling, hospice referral, planning with nursing home, etc.); and how the patients and/or family/caregiver was included.</i> 	<p>Score:</p> <p><input type="radio"/> 1</p> <p><input type="radio"/> 2</p> <p><input type="radio"/> 3</p>
<p>6.4 Develop enhanced care plans that are coordinated with school, nursing home, home care, chronic care, and/or end of life plans for identified high risk patients.</p> <p><i>Documentation:</i></p> <ol style="list-style-type: none"> 1. <i>Written explanation of how practice identifies high risk patients; and</i> 2. <i>Written description of the process for developing care plans for high risk patients and how they are coordinated with other significant stakeholders; and</i> 3. <i>Copy of 5 patient care plans documenting the coordination with other stakeholders.</i> 	<p>Score:</p> <p><input type="radio"/> 1</p> <p><input type="radio"/> 2</p> <p><input type="radio"/> 3</p>
<p>6.5 Work towards the use of or currently use electronic medical records.</p> <p><i>Documentation:</i></p> <ol style="list-style-type: none"> 1. <i>Written explanation of what is currently being utilized, if applicable; or</i> 2. <i>Written explanation of research completed on EMR options and estimated timeline for implementation.</i> 	<p>Score:</p> <p><input type="radio"/> 1</p> <p><input type="radio"/> 2</p> <p><input type="radio"/> 3</p>
<p>6.6 Demonstrate an increase in patient compliance with preventative care, ex. immunizations, cancer screenings, diabetes checks, heart disease screenings.</p> <p><i>Documentation:</i></p> <ol style="list-style-type: none"> 1. <i>Written explanation of preventive care focus and method for each to increase patient compliance; and</i> 2. <i>Data showing increase in patient compliance within the pilot period.</i> 	<p>Score:</p> <p><input type="radio"/> 1</p> <p><input type="radio"/> 2</p> <p><input type="radio"/> 3</p>

<p>6.7 Implement all three of these specific waste reduction initiatives: generic medication utilization, reducing avoidable ER visits and reducing hospital readmissions.</p> <p><i>Documentation:</i></p> <ol style="list-style-type: none"> 1. <i>Written explanation of additional waste reduction and how it will be implemented including patient engagement, staff responsibilities, and plan for monitoring; and</i> 2. <i>Written results of the original two initiatives from 4.2 with assessment of the results and next steps (ex. continue same process, modify process, etc.)</i> 	<p>Score:</p> <p><input type="radio"/> 1</p> <p><input type="radio"/> 2</p> <p><input type="radio"/> 3</p>
<p>6.8 Monitor the effectiveness of the intervention/project selected in Tier 1 Minimum Standard 4.2.</p> <p><i>Documentation: Written description of results of selected intervention including data and an assessment of the results and next steps (ex. continue same process, modify process, focus on another intervention, etc.)</i></p>	<p>Score:</p> <p><input type="radio"/> 1</p> <p><input type="radio"/> 2</p> <p><input type="radio"/> 3</p>

COMMENTS:

I certify that all of the Tier 2 Minimum Standards have been met to our satisfaction.

TransforMED Representative Signature

Title

Date

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

DHHS Representative Signature

Title

Date