

Cross Cutting Consumer Criteria for Patient-Centered Medical Homes

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A truly patient-centered medical home (PCMH) is grounded in comprehensive and well-coordinated primary care that treats the whole person and is consistent with each patient's unique needs and preferences. Patient-centered medical homes provide care that takes into consideration the patient's life situation, including his or her family and caregiver circumstances, as well as the patient's values and preferences, age and home environment when making health care and treatment recommendations.

A truly patient-centered medical home (PCMH) is grounded in comprehensive and well-coordinated primary care that treats the whole person and is consistent with each patient's unique needs and preferences.

Exemplar PCMHs utilize an interdisciplinary care team, provide ready access to care, partner with patients and their families at all levels of care and coordinate their care over time and across various settings and providers. The medical home also leverages the capacity of electronic health information exchange and strives to assure the highest possible quality of care and continuous quality improvement. It places a high priority on preventive care, care coordination and care management, including support for self-management, to help patients become and stay healthy.

PCMHs Provide Ready Access to Care

In a patient-centered medical home, patients and family caregivers have ready access to care. The practice:

- ▶ Ensures 24/7 provider availability by phone, email, video or in the office. In-office appointments and tele-consultations are scheduled promptly. The PCMH offers same-day appointments and accommodates walk-ins. Care team providers can rapidly access their patients' electronic medical records outside of conventional office hours.
- ▶ Accommodates the needs of patients with limited physical mobility, English proficiency, cultural differences or other issues that could impede access to needed examination and treatment, and/or impact patients' self-management ability.
- ▶ Facilitates patients' ready and appropriate access to services and providers outside of the practice.
- ▶ Has systems in place to help patients with health insurance eligibility, coverage and appeals, and to refer patients to helpful sources.

- ▶ Assesses whether cost is a barrier to patients' getting needed care/services and helps to meet those needs and/or connect patients and family caregivers to appropriate support.

PCMHs Effectively Coordinate Patient Care across Settings and Providers

The patient-centered medical home takes responsibility for coordinating its patients' health care across care settings and services over time, in consultation and collaboration with patients and family caregivers. The practice:

- ▶ Enables providers to practice within the full scope of their expertise, appropriately delivering minor procedures and other treatments that other primary care providers might refer out but that can be safely completed within the practice.
- ▶ Helps patients choose specialists and obtain medical tests when necessary. The patient's care team informs specialists of any necessary accommodations for the patient's needs.
- ▶ Helps the patient access other needed providers or health services (including providers or health services not readily available in the patient's community, e.g., in a medically underserved area).
- ▶ Has processes in place to effectively monitor and manage all tests, referrals, procedures and appropriate follow-up care.
- ▶ Ensures smooth transitions by assisting patients and families as the patient moves from one care setting to another, such as from hospital to home.
- ▶ Ensures that medications are actively managed and reconciled to avoid adverse interactions. Patients and their caregivers are valuable sources of information and are included in reconciliation processes. This helps ensure the accuracy and reliability of data stored in medical records while simultaneously empowering patients and their caregivers to be active partners in their health and health care.

In a patient-centered medical home, an interdisciplinary team guides care in a continuous, accessible, comprehensive and coordinated manner.

- ▶ The patient is both the center of the care team and a member of the care team. Patients are asked whom they want involved in their care and define who is considered a family caregiver. Practices respect patient choices and actively encourage family caregiver involvement.
- ▶ The care team demonstrates strong linkages with community resources, including those that provide non-medical services and support to vulnerable populations.
- ▶ The care team provides initial and routine assessments of patients' health status and places a high priority on preventive care, care coordination and chronic care management to help patients get and stay healthy and maintain maximum function.
- ▶ The care team is led by a qualified provider, and different types of health professionals, including non-physician providers, may serve as team leader.

The care team works together in a manner that facilitates continuous communication among both clinical and non-clinical staff. In a patient-centered medical home, patients and family caregivers are supported in managing the patient's health. The practice:

- ▶ Works with the patient and/or their caregiver to set goals for the patient's health and care and helps the patient meet these goals and manage health conditions.
- ▶ Integrates culturally appropriate community-based support resources – such as social services, transportation, peer support groups and exercise programs – into care plans.
- ▶ Assesses patients who are unable to effectively manage their own care because of cognitive or physical challenges and accommodates these patients by working with family caregivers, legal surrogates or other sources of support.

PCMHs Treat Patients as Partners at All Levels of Care Delivery

In a patient-centered medical home, patients, family caregivers and providers are partners in making key decisions. The practice:

- ▶ Meaningfully partners with patient and family caregivers at all levels of care, including at the point of care, in care redesign and in governance. At point of care, providers emphasize shared care planning, inclusive of shared decision making, joint goal-setting, collaborative care and treatment planning. The practice also encourages and supports patient and family participation in governance boards, quality improvement initiatives and Patient and Family Advisory Councils.
- ▶ Ensures that patients and family caregivers are provided useful, consumer-friendly educational information, including electronically, that helps them understand their conditions and the results of any medical tests or consultations (with both primary care providers and with specialists).
- ▶ Provides unbiased, evidence-based information on all treatment options, including possible side effects, costs and the benefits and risks of different options (including alternative therapies), so that patients can make an informed choice that reflects their personal preferences.
- ▶ Provides patients and family caregivers with timely access to the results of laboratory and other diagnostic tests through telephone, email, fax, personal health records and/or patient portals.

In a patient-centered medical home, open communication between patients and the care team is encouraged and supported. The practice:

- ▶ Knows about and overcomes any language, cultural, literacy or other barriers to ensure effective communication with patients, family members and other caregivers.
- ▶ Communicates information to patients and caregivers in plain language (rather than medical jargon), in patients' preferred languages, with links to explanatory, contextual information as needed and in a manner that is accessible to those with visual, hearing, cognitive and communication impairments.

The patient-centered medical home fosters an environment of trust, transparency and respect. The practice:

- ▶ Treats patients and family caregivers with dignity and respect.
- ▶ Respects patients' choice of treatment and provider.
- ▶ Works with patients and families to help them understand why and how patient health information will be stored, exchanged, used and protected; conveys the opportunity to opt-out of data-sharing; and clarifies other consumer rights and protections. The practice ensures that no treatment decisions are made without the patient's consent and understanding.
- ▶ Ensures that examinations and discussions with or about patients take place in a setting that affords appropriate privacy from other patients or staff.

PCMHs Commit to Delivery of High-Quality Care and Continued Quality Improvement

The patient-centered medical home provides care that is safe, timely, effective, equitable and patient- and family-centered. To accomplish this, the practice:

- ▶ Seeks out and encourages patient-reported data on health outcomes and patient feedback on their experience of care, and uses that information to improve the quality of care provided.
- ▶ Collaborates with patients and family caregivers in quality improvement strategies and practice redesign.
- ▶ Collects data on race, ethnicity, sex, gender identity, sexual orientation, primary language and language services for each patient and records that information in a manner that can be reported and used to plan and respond to the health and language needs of patients.
- ▶ Regularly evaluates and improves the quality, safety and efficiency of its care using scientifically sound measures. Quality performance information is reported to an entity and made publicly available in a manner that patients and caregivers can understand and access.
- ▶ Creates systems for medication reconciliation and shared medical records to help prevent errors when multiple clinicians, hospitals or other providers are caring for the same patient.
- ▶ Routinely undertakes efforts to identify and reduce any disparities in the quality of care provided to patients.
- ▶ Ensures all of its patients have equal access to high-quality care, regardless of source of payment.

PCMHs Commit to Patient- and Family-Centered Use of Health Information Technology

The patient-centered medical home robustly utilizes health information technology (HIT) and electronic health information exchange. HIT is a foundational element of improving a practice's ability to share information and communicate both amongst providers and with patients and families. The practice:

- ▶ Has ready access to the patient's complete, up-to-date medical history, including the patient's electronic health record, and shares summaries of care and other critical information with outside providers as appropriate.
- ▶ Ensures that patients and authorized family caregivers also have electronic access to the patient's electronic health record and are able to view, download and transmit the patient's health information. Online access to patients' health information is a critical tool for improving patients' knowledge about their health, empowering their ability to communicate with providers and increasing their desire to take proactive action to manage their health.
- ▶ Enables two-way communication with patients in and outside of in-person encounters, for example through secure email messaging and/or patient portals.
- ▶ Offers patients and family caregivers the ability to contribute information (i.e., patient generated health data) to their medical record that is relevant to their care. The information patients and their family caregivers provide about their abilities and need for self-management support complements clinical information to provide a comprehensive, person-centered view of the patient's health and health care needs.
- ▶ Ensures all patient-facing information and communication platforms are displayed in plain language, in patients' preferred languages, with links to explanatory, contextual information as needed, through accessible technology platforms (including mobile devices), and at no charge.