

Crosswalk Analysis: Montana SB84 Patient-Centered Medical Home Act and AAAHC Medical Home Certification / Medical Home Accreditation

Montana PCMH Requirements	AAAHC PCMH Certification Program <i>A focused review for Medical Home</i>	AAAHC Accreditation with Medical Home <i>A comprehensive review of an organization with Medical Home</i>
AAAHC STANDARDS Certification Standard identifier/Accreditation Standard identifier		
Section 3: subsection (4)(a) "Patient-centered Medical Home" means a model of health care that is:		
i) Directed by a primary care provider	Introduction to the Medical Home Standards: The services provided by a Medical Home are patient- centered, physician-, nurse practitioner-,* or physician- assistant-* directed, comprehensive, accessible, continuous, and organized to meet the needs of the individual patients served. <i>*as permitted by state law/regulation</i>	
	See below, Section 3: Subsection 6	
ii) Family-centered care	The Medical Home provides services within a team framework, and that "team" provider concept has been conveyed to the patient.	
	3.B/25.A.1	The patient can identify his/her Medical Home team members.
	3.C/25.A.4	The Medical Home explains information in a manner that is easy to understand.
	3.D/25.A.5	The Medical Home listens carefully to the patient.
	3.E/25.A.6	The Medical Home communicates effectively with the patient about his/her health care.
	3.F/25.A.7	The Medical Home provides instructions for taking care of individual health concerns
	3.G/25.A.6.I	The Medical Home documents important facts about the patient's health history.
	3.H/25.A.9	The Medical Home spends sufficient time with the patient.
	3.I/25.A.10	The Medical Home is as thorough as the patient feels is needed.

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ii) Family-centered care (cont.)	3.J/25.A.11	The patient is kept informed with regard to his/her appointment time, if delayed.
	3.K/25.A.12	The Medical Home addresses specific principles to prevent illness.
	3.L/25.A.13	The Medical Home interacts with the patient about making lifestyle changes to support wellness.
	3.M/25.A.14	The Medical Home inquires as to the patient's emotional health (e.g., concerns, worries, anxieties, personal and family relationships, and stressors).
	3.N/25.A.15	The Medical Home inquires as to the patient's mental health status (e.g., sad/empty or depressed).
	3.O/25.A.17	The family, responsible party or caregiver is included in patient care decisions, treatment, and education, as appropriate.
	/25.C.7	The needs of the patient's personal caregiver (see definition in Standard 25.A.5), when known, are assessed and addressed to the extent that they impact the care of the patient.
	/25.D.11	The transition of care (e.g. pediatric to adult or adult to geriatric) is proactively planned, coordinated and documented in the clinical record when indicated or when appropriate.
iii) Culturally effective	1.A/	Patients are treated with respect, consideration, and dignity
	3.P/25.A.18	The Medical Home treats its patients with respect and cultural sensitivity.
	3.Q/1.C	When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.
iv) Care that is coordinated	6.A/	The Medical Home has knowledge and provides coordination of care that includes:
	6.A.1/25.C.4	The coordination of available community and alternate health care resources.
	6.A.2/4.H.1,2	The coordination of consultations, referrals, and transfers of care, when appropriate.
	/25.C.6	Referrals are appropriate to the patient's needs; when referrals occur the Medical Home collaborates with the specialist.
	6.A.3/4.F.2	Provision for a timely exchange of information between the Medical Home and other providers and organizations relative to the patient's condition.
	6.A.4/25.D.4	Documentation of consultations in the clinical record.
	6.A.5/25.D.6	Documentation of results of patient referrals and follow up in the clinical record.
	6.B	When the patient is transferred from the Medical Home to the care of another health care professional.
	6.B.1/4.H.2	Arrangements with the receiving health care professional are completed prior to transfer.
	6.B.2/6.H	Clinical information is transferred.

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iv) Care that is coordinated (cont.)	6.C/6.J	A summary of significant past and current diagnoses is present in the clinical record.
	6.G/25.D.11	Transition of care (e.g., pediatric to adult or adult to geriatric) is proactively planned, coordinated, and documented in the clinical record when indicated or when appropriate.
	/25.A.16	The Medical Home provides services within a team framework, and that “team” provider concept has been conveyed to the patient.
v) Continuous care	6.H/4.E.7	Patients are informed as quickly as possible for follow-up regarding significant findings and laboratory or diagnostic imaging results.
	/4.E.8	Continuity of care and patient follow-up.
	6.I/4.I	When hospitalization is indicated, the Medical Home has an arrangement with a receiving hospital, or the provider has medical staff privileges at the receiving hospital.
	/6.N	The organization is responsible for ensuring a patient’s continuity of care. If a patient’s primary or specialty care provider(s) or health care organization is elsewhere, the organization ensures that timely summaries or pertinent records necessary for continuity of patient care are:
	/6.N.1	Obtained from the other (external) provider(s) or organization and incorporated into the patient’s clinical record.
	/6.N.2	Provided to the other (external) health care professional(s) and, as appropriate, to the organization where future care will be provided.
	6.J.A /25.D.1	The majority of medical appointments are with the same Medical Home team.
	7.D.11/25.D.9	Documentation regarding disposition of missed and cancelled appointments
	7. D.12/6.K	Significant medical advice given to the patients by telephone, including medical advice given after hours.
	7.E	The organization ensures that timely summaries or pertinent records necessary for continuity of patient care are obtained from other (external) provider(s) or organization(s) and incorporated into the patient’s clinical record.
	See below Section 5: subsection (7)(a)	

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vi) Comprehensive care	5.A/25.C	The Medical Home scope of services includes, but is not limited to:
	25.C.2.a	Preventive care including surveillance, anticipatory medical and oral health care guidance, and age-appropriate screening including well baby care.
	1/25.C.2.b	Wellness care, including healthy lifestyle issues (e.g., sleep, stress relief, weight management, healthy diet, oral care, and others)
	2/25.C.2.c	Health risk appraisal and health risk assessment and discussions with the patient.
	3/25.C.2.d	Acute illness and injury care
	4/25.C.2.e.	Chronic illness management.
	5/25.C.2.f.	End-of-life care.
	5.B/25.C.3	Patient education and self-management tools are utilized and documented.
	5.C	Health education is individualized and disease prevention information is based on the needs of the patient.
vii) Whenever possible, located in the patient's community	8.D	The organization facilitates the provision of high-quality health care by monitoring: <ol style="list-style-type: none"> 1. Appropriate and timely diagnosis based on findings of the current history and physical exam. 2. Medication review and update including prescription, over the counter, dietary supplements, and if indicated, use of recreational drugs and substances. 3. Appropriate ordering of diagnostic tests. 4. Absence of clinically unnecessary diagnostic or therapeutic procedures. 5. Appropriate management of patient referrals and consultations. 6. Infection prevention and control.
	5. D/25.C.4	The Medical Home has knowledge of community and alternate resources necessary to support the needs of the patient and his/her family.
viii) Integrated across systems	/25.C.5	The community's service limitations are known and alternate sources are coordinated by the Medical Home.
	See above iii) Coordinated Care and iv) Continuous Care	

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Section 3 Subsection 4 (b) Definition of PCMH Subsection		
Characterized by enhanced access	F.4. /25.B.3	Patients and staff are provided with information and explanation regarding: Provisions for after-hours and emergency care.
	/25.B.4	The Medical Home ensures on-call coverage (pre-arranged access to a clinician) when the Medical Home is not open.
	3.J/25.A.11	The patient is kept informed with regard to his/her appointment time, if delayed.
	4. A./25.B	The Medical Home establishes patient-driven access to care that includes: <ol style="list-style-type: none"> 1. Provider availability and accessibility 2. Appointment protocols for routine and acute care visits. 3. Diagnostic testing and treatment 4. Processes for obtaining consultations and providing referrals. 5. After-hours availability of care.
	4.B	The Medical home makes reasonable provisions to accommodate disabled patients.
	4.C	Information on access to Medical Home services is: <ol style="list-style-type: none"> 1. Obtained from patients on a regular basis. 2. Utilized to meet patient needs.
	4.D	The Medical Home ensures on-call coverage (pre-arranged access to a clinician) when the Medical Home is not open.
	/25.B.1	The Medical Home establishes standards in writing to support patient access, such as provider availability, treatment plan information, clinical record contents, advice, routine care, and urgent care; the Medical Home's data supports that they meet those standards.
	/25.B.2	Patients are routinely and continuously assessed for their perceptions about access to the Medical Home (provider availability, treatment plan information, clinical record contents, advice, routine care, and urgent care).
	/25.B.5	Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards.
4.E	Health information technology is continually assessed as a means to enhance electronic and	

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		telephone communications with patients such as secure messaging, scheduling, and patient education. IT is also considered and evaluated as a means to enhance clinical record-keeping.
Emphasis on prevention	See vi) Comprehensive Care	
	3.K./25.A.12	The Medical Home addresses specific principles to prevent illness.
	3. L/25.A.13.	The Medical Home interacts with the patient about making lifestyle changes to support wellness.
	/25.C.2.	The Medical Home scope of service includes, but is not limited to: <ul style="list-style-type: none"> a. Preventive care including surveillance, anticipatory medical and oral health care guidance, and age-appropriate screening including well baby care. b. Wellness care including healthy lifestyle issues such as appropriate sleep, stress relief, weight management, healthy diet, oral care, and others, as appropriate c. Health risk appraisal and health risk assessment and discussions with the patient.
	/25.C.3	Patient education and self-management resources are provided.
Emphasis on improved health outcomes	A Medical Home organization develops and implements a quality improvement program that is broad in scope to address clinical, administrative, and cost-of-care issues as well as actual patient outcomes .	
	8. G/25.E.6	The Medical Home's QI program includes at least one study every three years on each of the following <ul style="list-style-type: none"> 1. Patient/Primary care provider 2. Accessibility to care 3. Comprehensiveness of care 4. Continuity and/or coordination of care 5. Clinical Study
	8.B. /25.E.5	The Medical Home, with active participation of patients and professional staff, conducts ongoing, comprehensive self- assessments of the quality of care it provides
	8.C/25.E.3	The Medical Home incorporates current, evidence based guidelines and performance measures in delivering clinical services,
	/25.E.2	The Medical Home incorporates evidence-based guidelines and performance measures in delivering clinical services
	/25.E.4	Supervision of patient care by the Medical Home, as evidenced by: <ul style="list-style-type: none"> a. Appropriate and timely diagnosis based on findings of the current history and physical

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		examination. b. Medication review and update including prescription, over-the-counter, and diet supplements, and if indicated, use of recreational drugs and substances. c. Appropriate ordering of diagnostic tests. d. Absence of clinically unnecessary diagnostic or therapeutic procedures. e. Appropriate management of patient referrals (avoidance of unnecessary referrals).
	/25.E.6	In addition to the Standards presented in Chapter 5.I, the Medical Home’s quality improvement program includes at least one study every three years on each of the following topics: a. Patient/primary care provider relationship. b. Accessibility to care. c. Comprehensiveness of care. d. Continuity of care. e. Clinical study.
Emphasis on satisfaction	H.1/F.11	Patients are informed about procedures for expressing suggestions, concerns, complaints, and grievances, including the processes that are required by state and federal regulations.
	3.G	The organization periodically assesses patient satisfaction with services and facilities provided by the organization. The findings are reviewed by the governing body and when appropriate corrective action is taken
Section 3: Subsection 6 "Primary care practice" means a solo health care provider or a health care practice that is organized by or includes licensees under Title 37 who provide primary medical care, including but not limited to pediatricians, internal medicine physicians, family medicine physicians, nurse practitioners, and physician assistants.		
	See i) Primary care provider.	
	3.A/25.A.16	The Medical Home provides services within a team framework, and that “team” provider concept has been conveyed to the patient.
	3. B/25.A.1	The patient can identify his/her Medical Home team members.
	2.D	Governing body responsibilities include, but are not limited to: <ul style="list-style-type: none"> • Adopting policies to ensure that Medical Home health care professionals and staff are qualified to function in their current role. • The Medical Home is administered in a manner that ensures the provision of high-quality, patient-centered services. Ensuring Medical Home Health professional and staff maintain current qualification, including date sensitive credentials and privileges, as appropriate, to function in

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		assigned positions.
	/2.II	Covers requirements for Credentialing and Privileging. 2.III Peer Review
	/25.E.1	Patient care is directed by a physician, nurse practitioner, or physician assistant.
	8.A.1-4/4.A-C	Medical Home health professionals and staff supporting the organization: <ol style="list-style-type: none"> 1 Have the necessary training, skills and competencies 2 Practice their professions in an ethical manner 3 Are appropriately supervised 4. Are available to meet the needs of the patients
Section 5: subsection (7) In developing the standards described in subsection (2), the commissioner may consider:		
(a) The use of health information technology, including electronic medical records;	7.A./6	All patient information is reviewed and incorporated into the patient’s record in a timely manner.
	7. B	Clinical and health information relevant to the patient is readily available. Each Medical Home patient’s clinical record is complete and includes documentation of: <ol style="list-style-type: none"> 1. Relevant medical, family, and social history. 2 Wellness care including healthy lifestyle issues (e.g., sleep, stress relief, weight management, healthy diet, oral care, and others) as appropriate. 3. Health risk appraisal and health risk assessment and discussions with the patient. 4. Preventive care including surveillance, anticipatory medical and dental health care guidance, and age-appropriate screening. 5. Acute illness and injury care. 6. Chronic illness management. 7 End-of-life care.
(a) The use of health information technology, including electronic medical records; (cont.)	7.C	A summary of significant past and current problems and diagnoses is documented in the clinical record to facilitate the continuity of care.
	7.D	Each patient encounter includes entries in a clinical record for the visit. Such entries include, but are not limited to: <ol style="list-style-type: none"> 1. Date of visit. 2. Chief complaint or purpose of visit.

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		3. History. 4. Clinical findings. 5. Diagnostic and therapeutic studies and services. 6. Discharge diagnosis or impression. 7. Treatment plan.
	25.B.5	Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards.
Section 5: subsection (7) In developing the standards described in subsection (2), the commissioner may consider:		
(b) The relationship between the primary care practice, specialists, other health care providers, and hospitals;	See above iv) Care that is Coordinated , v) Care that is Continuous vi) Care that is Comprehensive The certifiable Medical Home recognizes the basic human rights and responsibilities of patients, as well as the necessity of maintaining a high-quality relationship with patients, their families, and caregivers. Within the patient-centered Medical Home, patients are empowered to take responsibility for their own health care. Such an organization has the following characteristics:	
	1.B	Patients are provided with appropriate privacy.
	1.C	Patient disclosures and records are treated confidentially, and patients are given the opportunity to approve or reuse their release, except when release is required by law.
	1.D	Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment, and prognosis. When it is medical inadvisable to give such information to a patient, information is provided to a person designated by the patient or to legal authorized person.
	1.E	Patients are fully empowered to participate in decision involving their health care, except when such participation is contraindicated for medical or legal reasons.
	1.F.7	Patients right to refuse to participate in experimental research when applicable
	1.F.8	Advanced directives as appropriate
(c) The access standards for individuals covered by a health plan to	1.F.9	The credentials of health care professional
	8.G/25.E	The Medical Home’s QI program includes at least one study every three years on each of the following topics: 2. Accessibility to care

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receive primary medical care in a timely manner;	2.II.B	The organization periodically assesses patient satisfaction and dissatisfaction with services and facilities. The findings are reviewed by the governing body.
	4.C	Information on access to Medical Home services is: 1. Obtained from patients on a regular basis. 2. Utilized to meet patient needs. See ii) above Family-centered care
Section 5: subsection (7) In developing the standards described in subsection (2) the commissioner may consider:		
(e) The use of comprehensive medication management to improve clinical outcomes.	7.D.8	Any changes in prescription and non-prescription medication with name and dosage, when available.
	8.D/25.E.4.b	The organization facilitates the provision of high-quality health care by monitoring: 2. Medication review and update including prescription, over the counter, dietary supplements, and if indicated, use of recreational drugs and substances.
	6.I.6	Entries in a patient's clinical record for each visit include, but are not limited to any changes in prescription and non prescription medication with name and dosage available