COMPARISON CROSSWALK BETWEEN
MONTANA SB 84 ("Patient-Centered Medical Homes Act") AND
JOINT COMMISSION PRIMARY CARE MEDICATION HOME CERTIFICATION
(Note: Requires Ambulatory Care Accreditation)

MONTANA SB 84	**JOINT COMMISSION 2011 PCMH**
Section 3: subsection 4(a)	*[Standards/Elements of Performance]*
i) Directed by a primary care provider	> Each patient has a designated primary care clinician. *[PC.02.01.01/EP 16]* > The organization allows the patient to select his or her primary care clinician. *[PC.02.01.01/EP 17]*
ii) Offers family-centered care	> The organization provides the patient with care, treatment, or services according to his or her individualized plan of care. *[PC.02.01.01/EP 1]* > The organization respects the patient's right to make decisions about the management of his or her care. *[RI.01.02.01/EP 31]* > The primary care clinician and the interdisciplinary team involves the patient in the development of his or her treatment plan. *[PC.02.04.05/EP 11]* > The interdisciplinary team works in partnership with the patient to achieve planned outcomes. *[PC.02.04.05/EP 9]* > The organization respects the patient's right and provides the patient opportunity to: *[RI.01.01.01/EP32]* ✓ Obtain care from other clinicians of the patient's choosing within the primary care medical home ✓ Seek a second opinion from a clinician of the patient's choosing ✓ Seek specialty care > The interdisciplinary team identifies the patient's health literacy needs. *[PC.02.02.01/EP 24]* > The primary care clinician and the interdisciplinary team incorporate the patient's health literacy into the patient's education. *[PC.02.02.01/EP 25]* > Patient self-management goals are identified and incorporated into the patient's treatment plan. *[PC.01.03.01/EP 44]* > The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient's individual needs. *[PC.02.03.01/EP 1]* > The clinical record includes the patient's self-management goals and the patient's progress toward achieving those goals. *[RC.02.01.01/EP 29]*

	> The organization communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families, and external interested parties. *[LD.03.04.01]* >The organization's design of new or modified services or processes incorporates the needs of patients, staff, and others. *[LD.04.04.03/EP 1]* > Leaders involve patients in performance improvement activities. *[LD.04.04.01/EP 24]*
iii) Culturally effective care	> The primary care clinician and the interdisciplinary team identify the patient's oral and written communication needs, including the patient's preferred language for discussing health care. *[PC.02.01.21/EP 1]* > The primary care clinician and the interdisciplinary team communicate with the patient in a manner that meets the patient's oral and written communication needs. *[PC.02.01.21/EP 2]* > The clinical record contains the patient's communication needs, including preferred language for discussing health care. *[RC.02.01.01/EP 1]* >The organization provides language interpreting and translation services. *[RI.01.01.03/EP 2]* > The clinical record contains the patient's race and ethnicity. *[RC.02.01.01/EP 28]*
iv) Coordinated Care & v) Continuous Care	> The organization coordinates the patient's care, treatment, or services based on the patient's needs. *[PC.02.02.01]* -- The organization has a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment, or services. -- The organization's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information. -- The organization coordinates the patient's care, treatment, or services. -- When the organization uses external resources to meet the patient's needs, it participates in coordinating the patient's care, treatment, or services. > The members of the interdisciplinary team provide comprehensive and coordinated care, and maintain the continuity of care. *[PC.02.04.05/EP 2]* > The primary care clinician is responsible for making certain that the interdisciplinary team provides comprehensive and coordinated care, and maintains the continuity of care. *[PC.02.04.05/EP 5]* *Note: Coordination of care may include making internal and external referrals, developing and evaluating treatment plans, and resolving conflicts in providing care.* > When a patient is referred to an external organization, the interdisciplinary team reviews and tracks the care provided to the patient. *[PC.02.04.05/EP 6]*

	> The interdisciplinary team acts on recommendations from internal and external referrals for additional care, treatment, or services. *[PC.02.04.05/EP 7]* >The clinical record contains information that promotes continuity of care among providers. *[RC.01.01.01/EP 8]* *Note: This requirement refers to care provided by both internal and external providers.* > The organization coordinates the patient education and training provided by all disciplines involved in the patient's care, treatment, or services. *[PC.02.03.01/EP 5]* >The organization has a process that addresses the patient's need for continuing care, treatment, or services after discharge or transfer. *[PC.04.01.01]* - The organization describes the reason(s) for and conditions under which the patient is discharged or transferred. - The organization describes the method for shifting responsibility for a patient's care from one clinician, organization, program, or service to another.
vi) Comprehensive Care	> The organization manages transitions in care and provides or facilitates patient access to: acute care; management of chronic care; behavioral health needs; preventive services that are age/gender specific; oral health; urgent and emergent care; substance abuse treatment. *[PC.02.04.03/EP 1]* *Note: Some of these services may be obtained through the use of community resources as available, or in collaboration with other organizations.* > The organization provides: ✓ Care that addresses various phases of a patient's lifespan, including end-of-life care *[PC.02.04.03/EP 2]* ✓ Disease and chronic care management services *[PC.02.04.03/EP3]* ✓ Population-based care *[PC.02.04.03/EP 4]*
vii) Located in patient's community	SEE BELOW: Section 3: Subsection 4(b) i) Characterized by enhanced access
viii) Integrated across systems	SEE ABOVE: iv) Coordinated Care & v) Continuous Care
Section 3: subsection 4(b)	
i) Characterized by enhanced access	> The organization provides patients with 24/7 access to: *[PC.02.04.01/EP1]* ✓ Appointment availability/scheduling ✓ Requests for prescription renewal ✓ Test results ✓ Clinical advice for urgent health needs *Note: Access may be provided through a number of methods, such as telephone, flexible hours, websites, and portals.*

	> The organization offers flexible scheduling to accommodate patient care needs. *[PC.02.04.01/EP 2]* *Note: This may include open scheduling, same day appointments, expanded hours, and arrangements with other organizations.* > The organization has a process to address patient urgent care needs 24 hours a day, 7 days a week. *[PC.02.04.01/EP 3]*
ii) Emphasis on prevention	> The interdisciplinary team assesses patients for health risk behaviors. *[PC.02.04.05/EP 12]* > Patient self-management goals are identified and incorporated into the patient's treatment plan. *[PC.01.03.01/EP 44]* > The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient's individual needs. *[PC.02.03.01/EP 1]* > The clinical record includes the patient's self-management goals and the patient's progress toward achieving those goals. *[RC.02.01.01/EP 29]*
iii) Emphasis on improved health outcomes	> The organization collects data on: ✓ Disease management outcomes. *[PI.01.01.01/EP 40]*
iv) Emphasis on satisfaction	> The organization collects data on: ✓ Patient experience and satisfaction related to access to care and communication *[PI.01.01.01/EP 16]* ✓ Patient perception of the comprehensiveness, coordination, and continuity of care *[PI.01.01.01/EP 16]*
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.	> <u>Definition of a Primary Care Clinician:</u> - A clinician operating within the primary care medical home who works collaboratively with an interdisciplinary team and in partnership with the patient to address the patient's primary health care needs. - Primary care clinicians have the educational background, broad-based knowledge, and experience necessary to handle most medical and other health care needs of the patients who have selected them, including resolving conflicting recommendations for care. - The primary care clinician is selected by the patient and serves as the primary point of contact for the patient and family. - A primary care clinician operating within the primary care medical home is a doctor of medicine or doctor of osteopathy, advanced practice nurse, or physician assistant.

Section 5: subsection (7) "standards commissioner may consider"	
(a) the use of health information technology, including electronic medical records;	> The organization uses health information technology to: *[PC.02.04.03/EP 5]* ✓ Support the continuity of care, and provision of comprehensive and coordinated care ✓ Document and track care ✓ Support disease management, including providing patient education ✓ Support preventive care ✓ Create reports for internal use and external reporting ✓ Facilitate electronic exchange of information among providers ✓ Support performance improvement > The organization uses an electronic prescribing process. *[MM.04.01.01/EP 21]* > The organization uses clinical decision support tools to guide decision making. *[PC.01.03.01/EP 45]*
(b) the relationship between the primary care practice, specialists, other health care providers, and hospitals;	> The organization has a process that addresses the patient's need for continuing care, treatment, or services after discharge or transfer. *[PC.04.01.01]* - The organization describes the reason(s) for and conditions under which the patient is discharged or transferred. - The organization describes the method for shifting responsibility for a patient's care from one clinician, organization, program, or service to another.
(c) the access standards for individuals covered by a health plan to receive primary medical care in a timely manner;	> The organization collects data on: ✓ Patient access to care within timeframes established by the organization *[PI.01.01.01/EP 41]* ✓ Patient experience and satisfaction related to access to care and communication *[PI.01.01.01/EP 16]* > The organization uses the data it collects on the patient's experience and satisfaction related to access to care and communication, and the patient's perception of the comprehensiveness, coordination, and continuity of care *[PI.03.01.01/EP 11]*
(d) the ability of the primary care practice to foster a partnership with patients; and	> The organization evaluates how effectively the primary care clinician and the interdisciplinary team work in partnership with the patient to support the continuity of care and the provision of comprehensive and coordinated care. *[LD.01.03.01/EP 20]*
(e) the use of comprehensive medication management to improve clinical outcomes.	SEE SPECIFIC STANDARDS IN THE MEDICATION MANAGEMENT CHAPTER <u>Overview of the Medication Management Chapter</u> Medication management is an important component in the palliative, symptomatic, and curative treatment of many diseases and conditions. However, medications are also capable of causing great harm if the incorrect dose or medication is inadvertently administered to a patient. To

	eliminate any potential harm that could be caused by medications, organizations need to develop an effective and safe medication management system. A safe medication management system addresses an organization's medication processes, which in many organizations include the following (as applicable): Planning; Selection and procurement; Storage; Ordering; Preparing and dispensing; Administration; Monitoring; Evaluation. The "Medication Management" (MM) chapter addresses these critical processes, including those undertaken by the organization and those provided through contracted pharmacy services. However, the specifics of the medication management system used by the organization can vary depending on the care, treatment, or services it provides. Effective and safe medication management also involves multiple services and disciplines working closely together. The medication management standards address activities involving various individuals within an organization's medication management system, such as licensed independent practitioners and staff. Additionally, an effective medication management system includes mechanisms for reporting potential and actual medication-related errors and a process to improve medication management processes and patient safety based on this information. In essence, a well-planned and implemented medication management system supports patient safety and improves the quality of care by doing the following: - Reducing variation, errors, and misuse - Using evidence-based practices to develop medication management processes - Managing critical processes to promote safe medication management throughout the organization - Standardizing equipment and handling processes, including those for sample medications, across the organization to improve the medication management system - Monitoring the medication management process for efficiency, quality, and safety