

# **Tri-state Child Health Improvement Consortium (Oregon, Alaska & West Virginia)**

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## **Alaska Medical Home Competencies**

### **Seven Core Medical Home Competencies**

DHSS has identified a set of seven core competencies that a primary care practice must attain in order to be a medical home. The seven core competencies include:

#### ***Competency #1: Patient Access.***

##### **Patient access encompasses:**

- a. improving the means by which patients can access primary care providers and their services by using non-traditional means such as email, text messaging, and telephone consultations; and enhancing depth of telemedicine capabilities.
- b. establishing a medical home relationship with a personal provider or care team such that each patient and his or her family has a specific primary care provider and care team that is taking responsibility for providing and managing his or her care, and building capabilities to complement primary care/medical home with care/case management for children.
- c. providing 24-hour access seven days a week to a member of the care team or a triage service trained to support a medical home by providing appropriate care or referrals rather than using the emergency department.

#### ***Competency #2: Accountability and Quality Improvement utilizing population approaches to care.***

##### **Quality improvement encompasses:**

- a. improving the degree to which health services for individuals and populations attain desired health outcomes and are consistent with current professional knowledge.

##### **Population approaches encompass:**

- a. using data to track the health status, and changes in health status, and to track delivery of evidence-based care to the practice's full population, and to subgroups

of the practice population;

- b. managing members of a population with a defined condition in a manner that proactively identifies and meets educational and service needs that address the targeted condition as well as all health care needs;
- c. emphasizing and documenting patient self-management

***Competency #3: Patient/Family Centeredness.***

**Patient/family-centered care is a negotiated agreement between patient/family and provider and encompasses:**

- a. patient/family education about the management of the patient's medical condition, and
- b. patient/family participation in selecting goals and strategies of patient and family-centered care, and in assessing if they are working.
- c. Patient/family participation in evaluating medical home performance.
- d. increasing transparency and communication around pediatric and pediatric subspecialty services.

***Competency #4: Continuous Culturally Effective Care.***

**Continuous Culturally Effective Care encompasses**

- a. Provider continuity,
- b. information continuity,
- c. encouragement of continuity of patient eligibility,
- d. geographic continuity,
- e. provisions for overcoming language barriers,
- f. recognition and respect for cultural background, beliefs, rituals and customs

***Competency #5: Coordinated and Clinically Managed Care.***

**Coordinated and clinically managed care encompasses:**

- a. care coordination for patients (and their families) who have current medical conditions and/or risk factors or who are healthy, but in need of services to prevent diminution of health status.
- b. clinical care management services for children with chronic conditions and/or special needs.

***Competency #6: Team-based, Comprehensive Care.***

**Team-based, comprehensive care:**

- a. means a care team, composed of at least the primary care clinician, another licensed care provider, and a care coordinator that assumes responsibility individually and collectively for providing and coordinating the provision of health and support services needed by the patient across the continuum of care. Team members may be located in different communities and coordinate care delivery through HIT, EHRs, HIE, Tele-Health or other effective communications.
- b. refers to the availability of a wide range of services in primary care, dental and behavioral health and their appropriate provision across the entire spectrum of types of needs for all but the most uncommon problems in the population by a primary care provider and/or care team. This includes services that promote and preserve health; prevent disease, injury and dysfunction; and care of illness, disability and discomfort as long as these needs are not too uncommon for the primary care practitioner to maintain competence.
- c. developing and improving communication and coordination of comprehensive care delivery

***Competency #7: Cost Control and Alternative Payment Options,***

Grantees will be encouraged (but are not required) to adopt cost controls, alternative provider compensation methods, or other strategies that alter the financial incentives of traditional fee for service (FFS) compensation, and to encourage effectiveness and efficiency rather than quantity.

Documentation of the services rendered, providers, settings, and results are required, as they are essential to the evaluation of the appropriateness of rates and evaluation of cost impact and quality improvement.

*Examples of alternative payment options are discussed in detail in Washington State Department of Social and Health Services “Payment Options and Learning Collaborative Work in Support of Primary Care Medical Homes.”*

[http://www.hca.wa.gov/documents/legreports/E2SHB2549\\_Medical\\_Homes\\_Report.pdf](http://www.hca.wa.gov/documents/legreports/E2SHB2549_Medical_Homes_Report.pdf)

Cost control and alternative payment options encompass:

- a. providing financial incentives to achieve efficiencies in health care delivery
- b. maintaining or reducing per-patient costs while improving overall population outcomes

## Other Medical Home Guidelines

DHSS recognizes that there are different ways to approach and attain the seven core medical home competencies, based on philosophy, practice size, geographic location, information technology infrastructure, staffing, population served, and other variables. The Office for Oregon Health Policy and Research publication, “Standards and Measures for Patient Centered Primary Care Homes” pp 15-31, sets out requirements and measurements for three tiers of medical homes. This publication is a useful guide in developing medical home parameters

[http://www.oregon.gov/OHPPR/HEALTHREFORM/PCPCH/docs/FinalReport\\_PCPCH.pdf?ga=t](http://www.oregon.gov/OHPPR/HEALTHREFORM/PCPCH/docs/FinalReport_PCPCH.pdf?ga=t)

Additional resources for identifying measures of accomplishment of medical home competencies include:

- the NCQA Standards and Guidelines for Patient-Centered Medical Homes <http://www.ncqa.org/tabid/631/default.aspx>
- AAP medical home standards <http://www.medicalhomeinfo.org/>,
- Washington State Department of Social and Health Services’ “Payment Options and Learning Collaborative Work in Support of Primary Care Medical Homes” (found at [http://www.hca.wa.gov/documents/legreports/E2SHB2549\\_Medical\\_Homes\\_Report.pdf](http://www.hca.wa.gov/documents/legreports/E2SHB2549_Medical_Homes_Report.pdf)).
- American Academy of Family Physicians <http://www.futurefamilymed.org>
- American Academy of Pediatrics: [http://aappolicy.aappublications.org/policy\\_statement/index.dtl#M](http://aappolicy.aappublications.org/policy_statement/index.dtl#M)
- American College of Physicians <http://www.acponline.org/advocacy/?hp>
- American Osteopathic Association <http://www.osteopathic.org>
- Washington State Medical Home <http://www.medicalhome.org/>
- Center for Medical Home Improvement <http://www.medicalhomeimprovement.org/>
- American College of Physicians [http://www.hhs.gov/healthit/ahic/materials/meeting03/cc/ACP\\_Initiative.pdf](http://www.hhs.gov/healthit/ahic/materials/meeting03/cc/ACP_Initiative.pdf)
- U.S. Department Health & Human Services: Agency for Healthcare Research and Quality (PCMH Resource Center [http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh\\_home/1483](http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483)
- *Crosswalk Between Tier Definitions and PPC-PCMH-CMS* [https://www.cms.gov/DemoProjectsEvalRpts/downloads/MedHome\\_AppendicesC\\_D.pdf](https://www.cms.gov/DemoProjectsEvalRpts/downloads/MedHome_AppendicesC_D.pdf)
- Oregon Medical Home Project <http://www.ohsu.edu/cdrc/medicalhome/index.html>
- Wisconsin Medical Home <http://www.wafp.org/pcmh/>
- Massachusetts General Hospital for Children <http://medicalhomedata.org/ViewDocument.aspx?item=509>
- Deloitte Center for Health Solutions <http://www.dhcs.ca.gov/provgovpart/Documents/Deloitte%20-%20Financial%20Model%20for%20Medical%20Home.pdf>
- Medical Home State Data Pages CAHMI <http://medicalhomedata.org/content/Default.aspx>

