<table>
<thead>
<tr>
<th>HCH Standard</th>
<th>HCH requirement</th>
<th>Patient-centered principle/intent</th>
<th>Current use of e-Health tools Common challenges Opportunities for the use of e-Health tools</th>
</tr>
</thead>
</table>
| Access & Communication (recertification) | Encourages patients to take an active role in managing their health by identifying and addressing at least one of the following:  
  • Readiness for change  
  • Literacy level  
  • Other barriers to learning | Patients are more likely to understand health instructions, education documents and teaching methods if factors that influence a patient’s knowledge, skills, ability, and willingness to manage his/her own health and care are considered in the clinic’s care delivery approach. | Current use:  
- Workflows using standardized communication and tools directed toward activating and engaging patient in their health and plan of care, such as the After-Visit Summary (AVS), Ask Me 3, teach back method, the Readiness to Change ruler, and the Agenda-Setting Chart  
- Visual tools (i.e. trend charts of lab results) that can educate patients and monitor progress towards goals  
- Tools and strategies used to inform care planning and understand patient needs and barriers to engagement (i.e. Patient Centered Assessment Method (PCAM), Patient Activation Measure (PAM), Lifestyle Overview (LSO), other screenings for needs related to social determinants of health) |
| Care Coordination (certification) | Identify a healthcare team that at minimum includes, the primary care provider (PCP), patient, and care coordinator. Together the team determines the frequency of contact, goals, and resources to support achievement of the goals. | Relationships between the HCH team, and the patient and family support the sharing of important information including patient and family goals and follow-up necessary to maintain optimal health. Patient-centered care is grounded in serving individuals and their families as equal members of the care team, working in partnership with the health care team, to make decisions about their care and to create a personalized plan. | Opportunities:
- Expanded use of the patient portal or other telehealth device to communicate with patients, such as the recording of self-monitored blood sugars, blood pressures, daily weights, or other measurements
- Patient facing apps that support self-management and healthy lifestyle choices |

| Care Coordination (recertification) | Provide patients the opportunity to participate and fully engage in planning their care, use shared decision-making regarding their care and provide input/feedback. | Shared decision-making is an approach in which clinicians and patients communicate and together use the best available evidence when planning and making decisions about patient care. | Current use:
- Standardized assessments built into EMRs trigger ‘best practice advisories’ based on patient response that can facilitate the goal setting process. 

| Opportunity: | Emerging technology around patient facing clinical decision support (CDS) tools and systems |
| **Care Planning (certification, adds external care plan elements at recertification)** | Establishes and implements a care plan policy that defines which patients would most benefit from one and guides how the care plan will be developed and used. | Not all patients with chronic or complex conditions will require a care plan. For some patients, a care plan is an effective tool that supports them in managing their health. | Current Use:  
- EMR functions which autopopulate care team members and other data from fields in the EMR to the care plan and/or other aspects of the patient record or continuity of care forms.  
- Longitudinal care plans across the care continuum  
Challenges:  
- EMR functionality can limit the development of a care plan that works for patients/families and care team.  
- Limited interoperability and health information exchange that impacts the ability of clinics to know about/have access to external care plans and other external data that may be needed to make a care plan comprehensive. |
| **Performance Reporting and Quality Improvement (certification)** | Uses a multidisciplinary quality team that includes patients and clinic staff involved in direct patient care and establishes procedures for sharing this work and eliciting feedback. | The perspectives of patients and families are a key factor in health care quality. Patient-centered care provides opportunities for individuals and their families to shape the design, operation, evaluation, and quality improvement of the HCH. | Challenges:  
- Recruitment/retention, meaningful engagement, and structure to include patient/family input at this level.  
- Framing quality improvement efforts of the clinic/org in a way that is meaningful to patients and therefore resulting in their engagement, input, and feedback. |
| Performance Reporting and Quality Improvement (recertification) | Demonstrates performance improvement and uses a quality plan that measures, analyzes, and tracks indicators from the Triple Aim components: patient health, patient experience, and cost-effectiveness. | Quality improvement in the HCH should pursue the Institute for Healthcare Improvement’s (IHI) ‘Triple Aim’ and measure progress towards that comprehensively. This includes obtaining feedback from patients/family about their healthcare experience and using this information for continuous quality improvement. | Challenge: Deploying a patient survey or tool that provides actionable (timely) and meaningful data with a good response rate across all patient groups. | Opportunity: Use of human centered design approaches to engage communities/patients/families in quality improvement initiatives and improvements in clinical operations. |