

Appendix 1: Medical Homes and Primary Care

What is a medical home? Why is it important?

The medical home is a concept first introduced by the American Academy of Pediatrics (AAP) in 1967. In its initial version, the AAP defined the medical home as the center of a child's medical records. At the time, the care of children with special health care needs was the primary focus of the medical home concept. Over time, however, the definition of the medical home has evolved to reflect changing needs and perspectives in health care.

The modern medical home expands upon its original foundation, becoming a home base for any child's medical and non-medical care. Today's medical home is a cultivated partnership between the patient, family, and primary provider in cooperation with specialists and support from the community. The patient/family is the focal point of this model, and the medical home is built around this center. Another key factor is that the focus of the medical home has shifted to include all children and adults, not just children with special health care needs. In the [2002 revision](#) (PDF - 45KB) of its [1992 statement](#) (PDF - 32KB) on the medical home, the AAP reiterated and enhanced its explanation of the medical home's crucial characteristics. These guidelines stress that care under the medical home model must be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. In 2007, the AAP joined with the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) to form the [Joint Principles of the Patient Centered Medical Home](#). Under this collaborative effort, the characteristics of the medical home have been defined within these 7 principles:

1. Personal physician:

- Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

2. Physician directed medical practice:

- The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

3. Whole person orientation:

- The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

4. Care is coordinated and/or integrated:

- Across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health

information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

5. Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making, and feedback is sought to ensure patients' expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

6. Enhanced access to care:

- Is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.


7. Payment:

- Appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:
 - It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
 - It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
 - It should support adoption and use of health information technology for quality improvement;
 - It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
 - It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
 - It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits.)
 - It should recognize case mix differences in the patient population being treated within the practice.

- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

The Maternal and Child Health Bureau (MCHB) at the Health Resources and Services Administration (HRSA) has identified specific criteria to establish whether a child's health care meets the definition of a medical home. This includes:

- Whether the child has at least one personal doctor or nurse who knows him or her well and a usual source of sick care;
- Whether the child has no problems gaining referrals to specialty care and access to therapies or other services or equipment;
- Whether the family is very satisfied with the level of communication among their child's doctors and other programs;
- Whether the family usually or always gets sufficient help coordinating care when needed and receives effective care coordination;
- Whether the child's doctors usually or always spend enough time with the family, listen carefully to their concerns, are sensitive to their values and customs, provide any information they need, and make the family feel like a partner in their child's care;
- Whether an interpreter is usually or always available when needed.

A medical home is an important mechanism for uniting the many segments of a child's care, including behavioral and oral health, to accomplish these goals. Furthermore, Drs. David Kibbe of the American Academy of Family Physicians and Joseph Kvedar of the Center for Connected Health at Partners HealthCare believe that [the medical home model of care works synergistically with participatory medicine](#)  (PDF - 455KB) models in which the active role of the patient is emphasized.

Developed by the Health Resources and Services Administration as a resource for health centers and other safety net and ambulatory care providers who are seeking to implement health IT.