

Criteria for Designating a Primary Care Practice (PCP) as a Medical Home¹

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The following table suggests general areas of quality improvement believed to be fundamental to the concept of a medical home². For each general area, 2-3 criteria are suggested as assessable indicators of a primary care practice’s achievement. Thresholds to attain designation or a credential as a medical home practice remain to be proposed, debated, and widely agreed to^{3,4}. This document has been prepared by the Iowa Medical Home Initiative (supported by the federal Maternal and Child Health Bureau and Iowa’s Early ACCESS Program) and led by Child Health Specialty Clinics (CHSC). The document has been prepared for use by the Affordable Health Care Commission and its assignees.

General Quality Improvement Areas (in no particular order)	Suggested Minimum Indicator Criteria for Each Quality Improvement Area
Family Involvement	<ul style="list-style-type: none"> • “Perceptions of care” feedback from patients/families with chronic conditions is systematically gathered (e.g. using surveys, focus groups, or interviews of ≥10 families) at least every six months. • There is an established process for practice staff to review this feedback and, based on the feedback, to plan and implement change. • Over time, the PCP builds a peer-to-peer partnership with selected patients/families who act as trusted advisors to the practice.
Care Coordination	<ul style="list-style-type: none"> • The PCP intermittently, but deliberately, asks any patient/family with a chronic condition what additional care supports they need. • The primary care provider or a staff member helps patients/families obtain resource information and coordinate appointments. • If not provided directly by the PCP, the practice assumes responsibility to connect patients/families needing care coordination with other available care coordination resources.
Special Patient Identification and Data Monitoring	<ul style="list-style-type: none"> • A registry list (electronic or otherwise) of patients with special health care needs⁵ is generated to enhance planning and delivery of quality care. • The registry list is used for flagging and monitoring such things as vaccines; use of other evidence-based clinical guidelines; sequential lab values; or abnormal test results. • Out-of-practice referrals are tracked and documented to assure that a full information picture about the patient/family is available to the PCP.
Continuity of Care	<ul style="list-style-type: none"> • The care team (including primary care physician, staff, and patient/family) collaboratively develops a care plan⁶ that identifies needs for services/referrals and assures communication between PCP, patient/family, and other care providers (e.g., specialists, cross-coverage providers, and emergency providers). • The care plan is shared with the patient/family and placed in the chart, along with documentation of where and to whom the care plan has been distributed. • The plan of care is reviewed, updated, and re-documented at least twice per year (at 6 month intervals) by the care team.

<p>Cultural Competence</p>	<ul style="list-style-type: none"> • The primary care practice (PCP) attempts to address obstacles of language, literacy, or personal preferences by having resources and information available for the most common diverse cultural backgrounds in the PCP’s catchment area. • When useful for care, individual patients/families are assisted through efforts to obtain interpreters or to access culturally-relevant information from outside sources. • Culturally-related accommodation needs are documented for future clinic visits.
<p>Transition Support⁷</p>	<ul style="list-style-type: none"> • PCP providers, on an intermittent basis, initiate and document age and situation-relevant discussions with patients/families about transition issues. • The primary care provider or a staff member assists patients/families to obtain resources useful for planning successful life transitions.
<p>Self-Management Support</p>	<ul style="list-style-type: none"> • The PCP assesses the patient’s/family’s ability to understand and manage their health condition. • Based on the assessment, the PCP assists the patient/family to live with their chronic condition using evidence-based self-management strategies⁸. • The self-management plan is reviewed and documented at intervals appropriate to patient/family needs.
<p>Practice-Based Continuous Quality Improvement</p>	<ul style="list-style-type: none"> • The PCP has its own documented systematic quality improvement mechanism for patient care, including use of evidence-based clinical guidelines. • Regular PCP provider and staff meetings discuss how to improve care and treatment, including reflections on the PCP’s use of evidence-based clinical guidelines; status of patient and staff satisfaction; and ease of patient/family access to care.

Notes:

¹ The recommended basic definition of “medical home” is a slightly modified version – the word “providers’ is substituted for the word “physicians” – of that proposed in the “*Joint Principles of the Patient-Centered Medical Home*” (American Academy of Family Physicians (AAFP); American Academy of Pediatrics (AAP); American College of Physicians (ACP); and American Osteopathic Association (AOA); March 2007):

“The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth, and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal providers, and when appropriate, the patient’s family.”

² Proposed general areas of quality improvement and specific indicator criteria were adapted and synthesized from work published by the Center for Medical Home Improvement; the National Committee for Quality Assurance (NCQA); the MacColl Institute for Healthcare Innovation; and the AAFP, AAP, ACP, and AOA (in the *Joint Principles of the Patient-Centered Medical Home*).

3. Designation of medical home status should reflect both existing and intended quality improvement criteria.. For example, to be designated a medical home, a practice should have implemented a to-be-determined acceptable subset of required criteria (as similarly proposed by the NCQA), as well as have an action plan with timeline for implementing currently unmet criteria.
4. A practice-friendly method of reviewing medical home status must be developed and shared with practices. Review characteristics might include web-based survey instruments; flexible application schedules; lunch-time site visits; easily completed checklists; certificates of training participation, etc.
5. A suggested inclusive and non-specific definition of patients with special health care needs is: “those who have, or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by patients generally (adapted from a Maternal and Child Health Bureau definition of children with special health care needs, 1998).
6. Suggested elements in the care plan, which is a summary, not a full medical record, include patient’s diagnoses; current health issues and treatments, including medications; family and medical history; immunizations; allergies; significant medical test results; possible emergency needs; primary care provider and specialist(s) involved in care; related school, community, and home concerns; and other useful contacts (e.g. insurance, care coordinator, pharmacy, home nursing agency, dentist, and health-related vendors).
7. Transition is a process that occurs at several major life junctures especially, early childhood to school entry; adolescence to independent adult living and work; and independent adulthood to elderly assisted living.
8. Examples of useful self-management strategies include personal goal setting; identification of barriers and challenges; personalized problem solving; and plans to obtain follow-up support.