

**Medical Home Reimbursement Project
Sample Medical Home Definitions & Standards**

<p>333 Washington State Medical Home Fact Sheet www.medicalhome.org/about/medhomeplan.cfm University of Washington Medical Home Leadership Network and state Department of Health</p>	<p align="center">Patient-Centered Primary Care Collaborative www.pcpcc.net</p>	<p align="center">The Commonwealth Survey <i>Closing the Divide: How Medical Homes Promote Equity in Health Care</i>, June 2007</p>
<p>Core elements of a Medical Home are:</p> <p>Accessible & Continuous</p> <ul style="list-style-type: none"> • Care is provided in the community • Changes in insurance providers or carriers are accommodated by the medical home practice <p>Coordinated & Comprehensive</p> <ul style="list-style-type: none"> • Preventive, acute care, specialty care, and hospital care needs are addressed • When needed, a plan of care is developed with the patient, family, and other involved care providers and agencies • Care is accessible 24 hours a day, 7 days a week • The patient's medical record is accessible, but confidentiality is maintained <p>Family-Centered</p> <ul style="list-style-type: none"> • Families and individual clients are involved at all levels of decision-making <p>Compassionate and Culturally Effective</p> <ul style="list-style-type: none"> • The patient's and family's cultural needs are recognized, valued, respected, and incorporated into the care provided • Efforts are made to understand and empathize with the patient's and family's feelings and perspectives 	<p>Characteristics and capabilities of a patient-centered medical home (PCMH):</p> <ul style="list-style-type: none"> • A personal physician who is accountable for taking care of all of a patient's health care needs • Collaboration with multi-disciplinary teams of physicians, nurses, caregivers, and other health professionals, both within a practice and through coordination of care with health professionals in the community, to assure that all of the patient's needs are met • Health information technologies to facilitate access to services and coordination and sharing of information among health professionals, caregivers and sites of service • Transparency and accountability for achieving better results through reporting on evidence-based measures of care <p>Medical home is "a physician-directed medical practice that provides point-of-entry, enhanced primary care in a continuous fashion, across the health care spectrum, and is comprehensive, coordinated and delivered in the context of family and community".</p>	<p>Used four indicators to measure the extent to which adults had a medical home:</p> <ul style="list-style-type: none"> • Have a regular doctor or place of care • Experience no difficulty contacting their provider by telephone • Experience no difficulty getting care or medical advice on weekends or evenings • Have doctors' office visits that are well organized and running on time <div style="background-color: #e0e0e0; padding: 5px; text-align: center;"> <p>ESSHB 2549, State of Washington, 2008 Regular Session, Section 3(3)</p> </div> <p>... reward primary care providers in the medical home collaborative that demonstrate improved patient outcomes & provide activities including:</p> <ul style="list-style-type: none"> • Ensure all patients have access to & know how to use a nurse consultant • Encourage female patients to have a mammogram on the evidence-based recommended schedule • Effectively implement strategies to reduce patients' use of emergency room care in cases that are not emergencies • Communicate electronically with patients • Effectively manage blood sugar levels of patients with diabetes

Note: Washington's work in defining medical homes generally has emphasized all types of primary care providers (physicians as well as others).

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Joint Principles of the Patient-Centered Medical Home*	
<p>The patient-centered medical home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family. Characteristics of a patient-centered medical home are:</p>	
<p>Personal physician. Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.</p>	<p>Quality and safety are hallmarks of the medical home:</p> <ul style="list-style-type: none"> • 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.
<p>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.</p>	
<p>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.</p>	
<p>Care is coordinated 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.</p>	
<p>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.</p>	
<p>Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. (The 7 specific payment principles are given in the Working Paper titled Sample Payment Goals / Guiding Principles.)</p>	
<p>* Principles jointly agreed upon by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA). Source: “Standards and Guidelines for Physician Practice Connections® - Patient-Centered Medical Home (PPC-PCMH™)”, <i>NCQA</i>, 2008, Appendix 1.</p>	

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**"Standards and Guidelines for
Physician Practice Connections® - Patient-Centered Medical Home (PPC-PCMH™)",
NCQA, 2008, Appendix 4.**

Standard 1: Access and Communication

- A. Has written standards for patient access and patient communication****
- B. Uses data to show it meets its standards for patient access and communication****

Standard 2: Patient Tracking and Registry Functions

- A. Uses data system for basic patient information (mostly non-clinical data)
- B. Has clinical data system with clinical data in searchable data fields
- C. Uses the clinical data system
- D. Uses paper or electronic-based charting tools to organize clinical information****
- E. Uses data to identify important diagnoses and conditions in practice****
- F. Generates lists of patients and reminds patients and clinicians of services needed (population management)

Standard 3: Care Management

- A. Adopts and implements evidence-based guidelines for three conditions ****
- B. Generates reminders about preventive services for clinicians
- C. Uses non-physician staff to manage patient care
- D. Conducts care management, including care plans, assessing progress, addressing barriers
- E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities

Standard 4: Patient Self-Management Support

- A. Assesses language preference and other communication barriers
- B. Actively supports patient self-management****

Standard 5: Electronic Prescribing

- A. Uses electronic system to write prescriptions
- B. Has electronic prescription writer with safety checks
- C. Has electronic prescription writer with cost checks****

Standard 6: Test Tracking

- A. Tracks tests and identifies abnormal results systematically****
- B. Uses electronic systems to order and retrieve tests and flag duplicate tests

Standard 7: Referral Tracking

- A. Tracks referrals using paper-based or electronic system****

Standard 8: Performance Reporting and Improvement

- A. Measures clinical and/or service performance by physician or across the practice****
- B. Survey of patients' care experience
- C. Reports performance across the practice or by physician ****
- D. Sets goals and takes action to improve performance
- E. Produces reports using standardized measures
- F. Transmits reports with standardized measures electronically to external entities

Standard 9: Advanced Electronic Communications

- A. Availability of Interactive Website
- B. Electronic Patient Identification
- C. Electronic Care Management Support

**** = must pass elements**

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Bridges to Excellence (BTE) Recognition as a Medical Home www.bridgestoexcellence.org			
<p align="center">Recognition as a BTE medical home requires achieving ...</p> <ul style="list-style-type: none"> • Level II or III in Physician Office Link, <i>and</i> • Level II or III in at least 2 of the 3 current condition-specific programs (diabetes, cardiac, back pain) 			
<p align="center">For condition-specific programs:</p> <ul style="list-style-type: none"> • Level I: Thresholds focus on above average performance, at about the 50th national percentile • Level II: Thresholds focus on really good performance, at about the 75th national percentile • Level III: Thresholds focus on very top performance, at about the 90th national percentile <p align="center">(in some cases there are "must pass" elements)</p>			
Physician Office Link	Diabetes Care	Cardiovascular & Stroke Care	Back Pain Care
<p>Level I: Evidence-based care & tracking</p> <p>Elements assess ...</p> <ul style="list-style-type: none"> • Use of evidence-based standards of care • Maintenance of patient registries to identify & follow-up with at-risk patients • Provision of educational resources to patients <p>Level II: Electronic systems</p> <p>Elements assess whether electronic systems are used to ...</p> <ul style="list-style-type: none"> • Maintain patient records • Provide decision support • Enter orders for prescriptions & lab tests • Provide patient reminders <p>Level III: Interconnected / integrated electronic systems</p> <p>Elements assess if electronic systems ...</p> <ul style="list-style-type: none"> • Are interconnected within a practice • Are interoperable (can talk to) other systems • Use nationally accepted medical code sets • Can automatically send, receive, & integrate data such as lab results and medical histories from other organizations' systems. 	<p>Level (I, II, or III) of practice performance is assessed based on meeting thresholds for:</p> <ul style="list-style-type: none"> • HbA1c control • Blood pressure control • LDL control • Eye exams • Foot exams • Nephropathy assessments • Smoking status & cessation advice or treatment 	<p>Level (I, II, or III) of practice performance is assessed based on meeting thresholds for:</p> <ul style="list-style-type: none"> • Blood pressure control (BP result) • Complete lipid profiles • Cholesterol control (LDL result) • Use of aspirin or another antithrombotic • Smoking status & cessation advice or treatment 	<p>Level (I, II, or III) of practice performance is assessment based on clinical thresholds & structural standards for ...</p> <ul style="list-style-type: none"> • Clinical Measures <ol style="list-style-type: none"> 1. initial visit 2. physical exam (must pass) 3. mental health assessment 4. appropriate imaging for acute back pain 5. repeat imaging studies 6. medical assistance with smoking cessation 7. advice for normal activities 8. advice against bed rest 9. recommendation for exercise 10. appropriate use of epidural steroid injections 11. surgical timing 12. patient reassessment 13. shared decision making (about surgery & its alternatives) • Structural Standards <ol style="list-style-type: none"> 14. patient education 15. post-surgical outcomes (must pass) 16. evaluation of patient experience