Medical Home Key Messages

What is a Medical Home?

A Medical Home is an approach to delivering primary health care through a 'team partnership' that ensures health care services are provided in a high quality and comprehensive manner.

Who can provide a Medical Home?

A primary care provider (physician or nurse practitioner) leads the medical home with the support and direction of the patient, the patient's family, clinic staff, community agencies, and other specialty care service providers.

What are the core components of a Medical Home?

Accessible & Continuous

- Care is provided in the community.
- Changes in insurance providers or carriers are accommodated by the medical home practice.

Coordinated & Comprehensive

- 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.

Family-Centered

- Families and individual clients are involved at all levels of decision-making.

Compassionate and Culturally Effective

- 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.

What are the benefits of a Medical Home?

Promotes Health through Prevention

- Preventive services such as annual physical exams, developmental screening, health education, immunizations, well-child care, and other medical and community-based services help maintain optimal health.
- Women who have a regular source of health care are more likely to access prenatal care.[1]
- Regardless of age, sex, race, or socioeconomic status—all people can receive an array of acute, chronic, and preventive medical care services through a medical home.[2]

Healthier Children and Families

- Among children with special health care needs (CSHCN), children with a medical home have less delayed care, less problems getting care, fewer unmet health needs, and fewer unmet needs for family support services.[3]
- In a study of medical home among CSHCN, parents reported improved care delivery, a decrease in the number of missed work days, and a decrease in hospitalizations.[4]

Reduce Health Care Costs

- Children who receive care in a medical home are half as likely to visit an emergency room or be hospitalized.[4]
- Having health care access through health insurance is not enough to avoid acute care and treatment costs – other issues such as quality of care and the relationship with a primary care provider also influence the use and cost of health care services.[5]

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[1] Braveman, P., Marchi K., Egerter S, Pearl M, Neuhaus J, Barriers to timely prenatal care among women with insurance: the importance of prepregnancy factors. Obstetrics and Gynecology. 2000: 95:874-880

[2] Kahn, Norman (2004). The Future of Family Medicine: A Collaborative Project of the Family Medicine Community.

[3] Strickland, B., et al. (2004). Access to the Medical Home: Results of the National Survey of Children With Special Health Care Needs. *Pediatrics* 113:5 (1485-1992).

[4] Palfrey, J., et al (2004). The Pediatric Alliance for Coordinated Care: Evaluation of a Medical Home Model. *Pediatrics*. 113:5 (1507-1516).

[5] Starfield, B & Shi, L (2004) The Medical Home, Access to Care and Insurance. A Review of Evidence. Pediatrics. 113: 1493-1498

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How many children and youth have Medical Homes in Washington State?

In Washington:

- 49% of children and youth aged birth to 17 years have a medical home.
- 45% of children and youth with special health care needs aged birth to 17 years have a medical home.[6]

Health insurance enhances the likelihood, but does not guarantee having a medical home.

- A little more than half of the children who have health insurance in Washington do not have a medical home.[6]

What are the challenges to creating a Medical Home?

Provider Reimbursement

- Increasing reimbursement to support care coordination services and screening is needed so that more health care professionals can provide a medical home.

Cost of Nonreimbursable Care Coordination Activities in a Medical Home Practice

- Although there are considerable long-term fiscal benefits of medical home, up-front costs are often borne by the medical providers and not currently reimbursable. One study estimates the annual cost of nonreimbursable care coordination in a pediatric practice would be $6600 for each primary care provider FTE (National Physician Fee Schedule Relative Value File Calendar Year 2000, Centers for Medicare and Medicaid Services).[7]

The Focus of Medical Care Delivery

- The medical care system puts too much emphasis on acute care rather than chronic and preventive care services that are provided in a medical home.

Technology Resources

- Some providers have limited or no access to health information technology to facilitate care coordination. Health information technologies are not coordinated across different medical sites.

Cultural Awareness

- More US medical schools are offering material on cultural awareness, up from 13% in 1991 to 87% in 2000, however the materials are not yet consistent.[8]
- Washington State's increasingly diverse population requires providers to become well versed in cross cultural communication and care.

Opportunities to Build a Foundation for the Medical Home Model

- Emergence of personal health records for patients can facilitate tracking and sharing of information across practices and payors of services.
- Additional billable codes are needed to reimburse care coordination services and screening that are necessary to provide a medical home.
- Tools/resources are being developed to help families and primary care providers strengthen the medical home model.
- Learning collaboratives and training initiatives for primary care practices are integrating components of the medical home into their curriculums.
- Adopting the Chronic Care Model would direct changes in primary care delivery that supports the creation of a medical home (www.improvingchroniccare.org.)

Key Messages Development and Contact Information

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[6] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. The National Survey of Children's Health 2003. Rockville, Maryland: U.S. Department of Health and Human Services, 2005.

[7] Antonelli, R., et al. (2004). Providing a Medical Home: The Cost of Care Coordination Services in a Community-Based, General Pediatric Practice. *Pediatrics*. 113:5. (1522-1528).

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