How Do I Judge the "Medical Homeness" of My Practice?

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ABSTRACT: A Medical Home provides care to infants, children and adolescents that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective. These desirable characteristics are often difficult to assess in ones practice. A recent policy statement from the American Academy of Pediatrics provides clarification and functional definitions of these characteristics. Tools and resources are available to aid physicians, clinic administrators and client-families in assessing their clinic's compliance with Medical Home characteristics, as part of a long-term quality improvement program for their practice.

The most common response of general pediatricians when asked if they provide a Medical Home for their patients is "I do that." However, when they review the desirable characteristics of Medical Home as described in the revised American Academy of Pediatrics (AAP) policy statement,[1] they quickly begin to realize that they may need to rethink that answer.

A Medical Home is not a building, house or hospital, but rather an approach to providing health care services in a high-quality and cost-effective manner. Seven core characteristics of the Medical Home were first adopted by the AAP in the original policy

statement of 1992.[2] These characteristics state that medical care should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. Functional descriptors of these characteristics were not expressed in the original statement. However, the 2002 statement provides tangible and desirable characteristics that define "Medical Homeness" of a primary care practice. These desirable and observable characteristics can aide a primary care practice in increasing its "Medical Homeness" via a quality improvement process.

The need for creating quality Medical Homes has been recognized in many other contexts since it became AAP policy. The Future of Pediatric Education II (FOPE II)[3] reinforces the concept by noting this as vital to preparing the pediatrician to meet the challenges of the delivery of health care in the future. The Federal Maternal Child Health Bureau (MCHB) has adopted the desirability of the presence of a Medical Home as a 2010 Health Objective for the nation,[4] as has the New Freedom Initiative.[5] Furthermore, all state Title V Children with Special Healthcare Needs (CSHCN) programs were asked by MCHB to report how many of the state's CSHCN population have a Medical Home.[6] The definition of CSHCN used by MCHB is: "Children, birth to 21 years, with or at risk for chronic physical, developmental, behavioral or emotional conditions and who require health and related services of a type and amount beyond that required by children generally".[7-8] MCHB has focused much activity around creating functional Medical Homes for children with special health care needs, realizing this cohort of children and families can benefit even more than the typical child. Since 2001, seventeen states have received Special Project with Regional and National Significance (SPRANS) grants to improve the quality and availability of Medical Homes in their population.

The characteristics of a successful Medical Home were strongly influenced by the opinions of family members of CSHCN. A national survey entitled "Your Voice Counts!!" was done by Family Voices[9] to determine how the families of CSHCN perceived the medical care they received and what they felt would improve the delivery system. Also, in a survey of parents of CSHCN and physicians,[10] large differences were

noted in the way each group prioritized useful services. Data gathered in surveys and studies were vital in delineating the desired characteristics of the Medical Home.

A multi-module Medical Home Training Curriculum (available at www.medicalhomeinfo.org)[11] has been developed as a cooperative activity between the AAP, MCHB, Shriner's Hospitals, National Association of Children's Hospitals and Related Institutions (NACHRI), and Family Voices. It has been and continues to be presented at various sites around the country. This program covers the wide range of topics that constitute the Medical Home concept. The content of the curriculum can be locally modified to most appropriately address the issues pertinent to the area where it is being presented.

Studies of families and physician practices that have utilized the Medical Home principles have established that the following benefits are realized:[12-14]

- increased patient and family satisfaction.
- establishment of a forum for problem solving
- improved coordination of care
- enhanced efficiency for children and families
- efficient use of limited resources
- increased professional satisfaction results
- increased wellness resulting from the comprehensive care.

The 2002 policy statement, most importantly, described desirable characteristics that are the functional activities that make the Medical Home come to life for practices, physicians and families. Because the original 1992 statement[2] did not include these characteristics, much confusion and extremely varied individual interpretations of achieving a true Medical Home ensued. The 2002 policy statement provides an expanded and more comprehensive definition of the Medical Home desirable characteristics. A description of how these desirable characteristics can be used to critique an individual's practices for "Medical Homeness" follows.

There are several attributes that help denote a practice as ***Accessible***. The practice location should be physically and financially accessible, but equally important is the easy availability of direct physician-family communication.[12] One technique for improving communications involves each Medical Home practice identifying their population of CSHCN and giving them a group-identifying name.[12] The use of a group-identifying name alerts the office personnel that the case is not routine and that someone who knows the child and family should handle the request. This avoids the frustration felt by family members having to serially repeat their child's medical history. To make this work in a busy practice setting requires that families are also knowledgeable partners who understand the urgency or routine nature of their needs.

The development of a true partnership between the family, the child, and the physician is the basic element of ***Family-Centered***. Family-Centered services have been shown to result in greater satisfaction for families,[15] which leads to increased adherence to treatment recommendations which then leads to less parental distress and depression.[16-17] Familiarity and trust between families, children and physicians must be fostered and respected. For a family to perform well as the principal source of care and support for their child, its members have to be well taught concerning their child's medical and non-medical issues. When families have this knowledge, their opinion about acute changes in condition should be heard and become part of any action plan.

Continuous notes the desirability of having the same primary care physician from infancy to young adulthood. Starfield,[12] Christakis,[14 & 18] and Wissow[19] have shown the benefits of seeing the same physician for most of the child's care. This, unfortunately, is not always easily achieved with our highly mobile population, multi-partner practices, (use of physician extenders) and third-party payer limitations. Participation in the many transition issues that arise for CSHCN is a real challenge to continuity. Planning for hospital-to-home, home-to-school, changes in health status, school-to-work and moving to adult-oriented providers are only a few of the transition challenges that arise. Resources to address these challenges can be found at: www.hrtw.org[20]

All pediatricians would like to feel that their care is ***Comprehensive***. The Medical Home policy statement extends this concept well beyond just the medical care needed by stating "the child's or youth's and family's medical, educational, developmental, psychosocial and other service needs are identified and addressed".[1] Children with chronic conditions who received "non-medical" family support demonstrated positive effects in adjustment compared to a cohort of children who did not receive such support.[21] Children with a personal doctor are more likely to receive comprehensive care than children without a personal doctor.[13] To address all these needs is a real challenge for one physician. It requires extra time (a precious commodity) and discussion with the child's family. It requires a knowledge of multiple, often non-medical, systems that are needed to make a complete service plan for many CSHCN. The delivery of all primary care services to a child and family is especially difficult when overlaid with a chronic condition.[12] The relationship between primary care physicians and subspecialists must be one of easily shared information, generated by both professionals. A clear delineation of responsibility between all parties involved in providing services is required. All services should be included in a written care plan that was mutually designed by the parent-physician partnership. Referrals and service requests need careful consideration by the partnership for necessity and applicability before they are approved.

Additionally, as part of comprehensiveness, the child and family's needs should be prospectively identified through screenings. The quality and timing of screenings for the multiple areas that are being recommended will require dedication to this principle to accomplish. The screening component of the Medical Home training curriculum suggests that all screenings be done with a validated and scored instrument that would standardize all screening activities. Extra time for visits may need to be scheduled which may be an issue with many capitated, managed-care organizations.

Of special importance in the success of a Medical Home are the ***Coordination*** activities, which are intended to link children and families to resources and services in a coordinated effort to maximize the potential of the child and provide optimal health care.[22] After the written care plan is designed, all involved service providers must have a

copy and understand their roll in its implementation. Providers may include educational or other non-medical community-based services and organizations. The completeness of the medical record also becomes an important factor in quality coordination activity. The family should have in-hand documentation of care plan and historical information. Formats for organizing this information have been designed, one useful and simple format was jointly developed by the American College of Emergency Physicians and the AAP[23] and can be downloaded (http://www.pediatrics.org/cgi/content/full/104/e53)[24] and printed as hardcopy or edited and saved digitally. The plan of care will be strengthened by incorporating information gained during referral visits, evaluating the effectiveness of current services and appropriately updating the plan after periodic review by the partnership.

In offices currently striving for Medical Home excellence, a specific nurse provided by the practice or by external agencies (Title V programs or MCO entities, for example) has assumed a large role in helping with the care coordination activity. Additionally, many family members become quite accomplished in coordinating their own service needs. However, aid in gaining access to needed services will be critical for inexperienced families and for those capable families worn out coordinating their own services. Linkage of families to parent-to-parent or other support groups has repeatedly been shown to dramatically add to their ability to cope with their special situations.

Compassionate may be the most elusive of the desirable characteristics of the Medical Home. Concern for the well being of the child and family should be expressed and demonstrated in both verbal and nonverbal interactions. The context of well-being should transcend the purely medical issues of concern and address non-medical problems such as financing, employment, housing, discrimination, education, sibling relationships and recreation. Focused effort should be made to understand and empathize with the feelings and perspectives of the family as well as the child or youth. This characteristic centers on the need to be open-minded and not to judge from your own societal or professional biases.[25] If any simple action could be applied to this component of the

Medical Home, it would be to listen carefully as care plans are developed by the parent-professional partnership.[26]

As the US becomes increasingly diverse, large health systems have struggled with service provision to patients from distinct cultural and often non-English speaking backgrounds. It is becoming increasingly incumbent upon the primary care physicians of these patients to cross the cultural and linguistic gap. A fully functional Medical Home may be the only interface between the medical system and a CSHCN family where care is delivered in a ***Culturally Effective*** manner. Inherent in every desirable characteristic of a Medical Home is a recognition of and respect for the beliefs, customs, language and heritage of the families with whom a relationship is being forged and a care plan being developed. Care is taken to avoid superimposing one's own culture or belief systems, applying stereotypes and making assumptions about the patient's culture, or leaving identified cultural issues unacknowledged.

The AAP has focused special attention on *culturally effective* care, having released a policy statement from the Committee on Pediatric Workforce.[27] This statement, much like the Medical Home concept, emphasizes the dynamic relationship needed between patient and provider to achieve care that is more than culturally sensitive or competent. On a federal level, the Office of Minority Health issued National Standards for Culturally and Linguistically Appropriate Services in Health Care in 2001,[28] followed by a guide to the application and implementation of these 14 standards in 2002 (http://www.omhrc.gov/clas/guide2a.asp).[29] The importance of providing full language access to the pediatric patient and family of limited English proficiency, especially in the face of special needs, cannot be overstated.[30] Care mediated through untrained ad-hoc interpreters, inadequately trained professional interpreters, or without an interpreter, has recently been shown to be fraught with errors and potential clinical consequences.[31]

Primary care practices that are dedicated to the Medical Home concept are encouraged to implement these desirable characteristics as part of their quality improvement process, with the involvement of families in this process. It is unlikely that any practice will ever

achieve complete harmony with all the Medical Home characteristics, however, improving the quality of care is longitudinal and a "successive redefinition of the unobtainable".[12] The Medical Home Index, which has physician and family indexes, can be used to evaluate the status of a practice from both the physician's and family's perspective. This tool focuses attention on each of the Medical Home components and is a guide to areas of needed quality improvement. It is available at www.medicalhomeimprovement.org/outcomes.htm.[32]

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