Issue Brief

Implementing the Medical Home in Medicaid, CHIP, and Multistakeholder Demonstration Programs

Introduction

The medical home is quickly spreading throughout the health care system as an innovative model for delivering high-quality, culturally effective, integrated care that has the potential to lower costs and improve quality and patient satisfaction. Recent reports of state Medicaid, Children's Health Insurance Program (CHIP), and multistakeholder demonstration activity indicate that most states are now either implementing or planning to implement some form of medical home project in state Medicaid, CHIP, or other programs. Many, but not all, of these medical home projects involve pediatrics.

In addition, current health care reform efforts at the federal level include significant new funding for Medicaid medical home demonstration programs. Should these provisions be included in a final bill, state Medicaid medical home demonstration programs will grow exponentially.

AAP chapters remain the best resources for states planning for and implementing medical home projects in Medicaid, CHIP, or multistakeholder demonstration programs. AAP chapter expertise will ensure that the unique needs of children and pediatricians are met when such projects are created.

AAP chapters are encouraged to review the linked documents in the State Activity section of this Issue Brief to learn more about what may be going on in your state. In addition, AAP chapters are encouraged to contact state Medicaid Director offices to learn more about state activity or to offer chapter involvement.

AAP chapter representatives do not need to know everything about the medical home to become involved at the state level. The AAP has many resources – including this document – to assist you.

This Issue Brief serves to provide guidance to AAP chapters working with states to implement medical home projects in Medicaid and CHIP as well as multipayer demonstration programs, either through legislation or through administrative changes. It also addresses a number of the policy questions that frequently arise in creating state supports for the medical home. AAP chapters with questions should not hesitate to contact the AAP Division of State Government Affairs for additional information or consultation, at 800/433-9016, ext 7799 or stgov@aap.org.

Overview

The medical home was first developed by the American Academy of Pediatrics (AAP) in 1967, evolving over time to encompass a pediatrician's practice as the ongoing connection between the many disparate facets of the health care system for children with special health care needs (CYSHCN). In a medical home, the pediatric practice coordinates care across a spectrum of programs and services. The medical home has since expanded and evolved, and today serves as a model for the provision of health care for **all** children and youth.

In 2002, the AAP published its policy statement, The Medical Home. This statement describes care in a medical home as accessible, continuous, comprehensive, family-centered,

coordinated, compassionate, and culturally effective. This policy statement was reaffirmed in 2008.

In 2007, the AAP joined the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) in signing onto the Joint Principles of the Patient-Centered Medical Home (Joint Principles) document. These principles provide the foundation for practices, systems and programs that implement the medical home model.

As detailed further in the Joint Principles, the medical home is characterized by the following (summarized):

- **Personal physician** – each patient and his/her family has an ongoing relationship with a personal physician who provides first contact, and continuous and comprehensive care
- **Physician directed medical practice** - the personal physician leads a team of health care professionals who collectively take responsibility for the ongoing care of patients
- **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
- **Care is coordinated and/or integrated** across all elements of the complex health care system (eg, subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (eg, family, public and private community-based services)
- **Quality and safety** are hallmarks of a medical home
- **Enhanced access** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physicians, and practice staff
- **Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home

Focusing on the specific needs of children, the AAP has developed a preamble to these joint principles emphasizing:

- The **family-centered partnership** with children and families
- The **community-based system** in which the medical home participates
- The specific importance of **transitions** for children from pediatric to adult care
- The critical importance of **value** and **appropriate financing**

In 2008, the Academy also released The Medical Home for Children: Financing Principles, which provide detailed AAP recommendations for financing and payment for the various components of, and services provided in, the medical home. This includes payment based on a contact or visit-based fee, a care management fee, and a performance or pay-for-performance (P4P) fee. In 2008, the Academy also released the Index of CPT Codes for Medical Home, to help pediatricians better understand CPT codes for services provided in a medical home setting.

Today, the medical home model is spreading throughout public and private health care systems, and numerous payers are working on medical home pilot projects to implement and evaluate the model. The Academy continues to work as a member of the Executive Committee and through the many centers of the Patient Centered Primary Care Collaborative (PCPCC), a coalition of major employers, consumer groups, quality organizations, health plans, labor unions, hospitals, physician organizations and many others who have joined together to advance the medical home. As a national coalition of over 500 members, the PCPCC acts to share medical home information, evaluate medical home systems, promote financing reform, and promote medical home implementation across numerous areas of the health care system.

Many state Title V programs have also been working on the medical home for many years. The AAP continues to partner with the Association of Maternal and Child Health Program (AMCHP) and its ongoing work with state Title V programs on this critical issue.

Another organization highly involved in spread of the medical home model in state Medicaid and CHIP programs is the National Academy for State Health Policy (NASHP). Through a series of conferences, Webinars, and papers, as well as a series of state consortia, NASHP has worked to build upon existing state success with medical home, and share information with states and various players. The Academy continues to work with NASHP in this endeavor to ensure that the needs of children and pediatricians are met as medical home programs are developed.

Through these activities and in work with countless other organizations in the public and private sector, the AAP continues to advocate for the widespread adoption of the medical home model and to ensure that the needs of children, youth, families

and pediatricians are addressed as medical home programs are created.

State Activity

Today, a number of states are examining the potential of medical home to transform health care provided in state programs. States are investigating the model as a way to improve quality, reduce the use of unnecessary services, and ensure coordination of care across systems.

Legislation is not required to create medical homes for children; however legislators, state officials, and insurance plan administrators can take many steps to improve health care systems, administration, financing, and payment to support the medical home, whether through legislative or administrative opportunities. Numerous states have implemented medical home projects in Medicaid, CHIP, or multistakeholder demonstration programs; a number have focused on children.

State legislation on the medical home has varied widely, from creating a framework for state program implementation, to more detailed, specific requirements for participation in new medical home programs. Increasingly, state medical home legislation acts as enabling legislation, creating the parameters of the state medical home project and authorizing a particular state agency to further create plans for the project.

Should your state pursue medical home legislation, it is important that stakeholders have a clear understanding of the implications of what is included in the language of the bill. There are no hard and fast recommendations as to what should and should not be included in state medical home legislation – in most instances legislative language will be specific to the needs and political environment in each state. Therefore, what is included in a medical home bill in your state legislature and what is left to state agency implementation will likely be unique.

AAP Guidance: As a general rule, medical home legislation should not be so prescriptive as to limit flexibility in designing the medical home project, or make it difficult for practices to participate. However, legislative language should not be so loosely defined that the medical home project will not meet the needs of pediatricians or the children in their care.

State medical home project activities to date, with or without legislation, have varied in scope and breadth. AAP chapters are encouraged to review summaries of existing state medical home plans, available in a summary table from the National Partnership for Women & Families, an Excel file that is the result of NASHP's state scan of medical home activities, a map of such activities, and a chart of state involvement in multipayer demonstrations. In addition, the PCPCC has published a pilot guide, providing detailed information on pilot projects – many in the private sector – taking place across the country.

State Planning

State Medicaid and CHIP medical home projects involve and will impact countless facets of the health care system. Partnerships in building and sustaining medical home projects are critically important. AAP chapters should work together with key stakeholders, including:

- State Medicaid/CHIP officials
- Key legislators and governor's office staff
- State Title V officials
- Other payers as appropriate (in the case of multistakeholder demonstration programs)
- Officials from other state programs and institutions that will interact with the medical home (eg, Early Intervention services, mental health, education system, Head Start, day care, foster care, oral health, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), others)
- State health information exchange projects and/or other health information technology (HIT) experts
- The state chapters of the American Academy of Family Physicians (AAFP), American College of Physicians (ACP) and American Osteopathic Association (AOA)
- The state medical association and other physician organizations
- Members of the business community
- Practice managers
- Families
- Employers/purchasers
- Community groups
- Patient and family advocacy groups (eg, Family Voices and the National Partnership for Women & Families)
- Quality improvement specialists

AAP Guidance: States should establish medical home advisory committees to provide input and counsel to the creation, ongoing implementation, and evaluation of the state medical home project. These committees should include representation from all stakeholders in the medical home project. AAP chapter representation on such committees is critical to ensure the project meets the health care needs of children and the practice needs of pediatricians.

Policy Considerations

Whether implemented through state legislation or separately through state agency planning activities, states will likely need to evaluate the following policy components of state medical home plans. The following provides guidance on these considerations when implementing a medical home program:

Definition of Medical Home

State medical home legislation and state medical home implementation plans have defined "medical home" to various degrees. In some instances these definitions have been extensive, in others they have been less specific. The benefit of a clear definition of the term "medical home" is that it makes your state's project more concrete and clearly defines its goals. A concern with too extensive of a definition, especially in state legislation, is that it might be so rigid that meeting its standards would be impractical and too difficult for practices.

AAP Guidance: The AAP recommends that state definitions of medical home refer to language used in the Joint Principles signed onto by the Academy, with additional language from the Academy's preamble for pediatric care for children. Such a definition may then be supplemented by language from the Academy's policy statements, The Medical Home, and Family-Centered Care and the Pediatrician's Role.

In a June 2009 NASHP report of 10 study states that have moved to implement the medical home in Medicaid/CHIP, NASHP found that 4 of the 10 states adopted the Joint Principles for purposes of their medical home definition, while others developed their own definition. While not the same across states, most definitions do include the involvement of a personal physician who provides first contact and ongoing, comprehensive care over time, taking into consideration a patient's condition, other health and human services professionals, and various settings where care may be provided.

Each AAP chapter should be comfortable with the scope of its state's definition of medical home, and understand the implications for its use. The state definition should be shared widely and used consistently, to ensure that knowledge of the term and its exact use grows among lawmakers, state officials, physicians and other health care professionals, health care organizations, community organizations, employers and other health care purchasers, enrollees and their families.

Medical home recognition

With a working definition of medical home in place, states will seek to clarify the requirements practices must meet in order to be recognized as medical homes. There are a number of ways states may do so, and states should convene relevant stakeholders to develop such standards – AAP chapters are strongly encouraged to be a part of such discussions.

AAP Guidance: The AAP recommends voluntary medical home recognition, rather than required certification.

The National Committee for Quality Assurance (NCQA) has developed a widely recognized medical home assessment tool, the Physician Practice Connections – Patient Centered Medical Home (PPC-PCMH) tool. The PPC-PCMH standards "emphasize the use of systematic, patient-centered, coordinated care management processes," and were developed with input from the AAP, AAFP, ACP, and AOA. The Academy continues to advocate for more pediatric and family components within the NCQA recognition standards.

The AAP has created the Building Your Medical Home toolkit to assist pediatric practices in their efforts to transition to the medical home model and meet the NCQA PPC-PCMH recognition standards. The toolkit serves as a crosswalk between each of the toolkit building blocks and the NCQA PPC-PCMH Recognition Program 'must pass' elements.

A number of state pilot projects have developed their own medical home recognition standards, sometimes utilizing the NCQA PPC-PCMH as a starting point. For example the state of **Colorado** developed its own medical home standards, after surveying hundreds of physicians and other stakeholders and evaluating existing tools and other resources.

The National Center for Medical Home Implementation has also developed a monograph entitled *Measuring Medical Homes: Tools to Evaluate the Pediatric Patient- and Family-Centered Medical Home*, which presents various tools available and in use to identify, recognize, and evaluate a practice as a pediatric medical home.

AAP Guidance: It is imperative that states work with AAP chapters when developing/implementing the state medical home recognition tool. To the extent possible, recognition tools should be evidence-based, and should reinforce the Joint Principles. States should ensure the feasibility of meeting its recognition standard and provide appropriate training, educational, administrative, and financial support so that participating practices can do so.

Personal physician

The medical home calls for each child and his/her family to have an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care. The physician and his/her practice coordinate a child's care across the health care spectrum, ensuring that all needed services are provided in a culturally and linguistically appropriate way. State Medicaid and CHIP programs can implement policies to support, strengthen, and maintain a child's ongoing relationship with a personal physician.

> **AAP Guidance:** The AAP recommends that states:
>
> • Ensure each child has a clearly identified personal physician - preferably a pediatrician - with whom the family is comfortable, who knows and understands the health care needs of the child and has the resources and capacity to meet those needs.
>
> • Allow families adequate time to choose a personal physician before auto-assigning one.
>
> • Take into consideration siblings and travel distances to practices when assigning families to a physician. For example, states should assign all children from the same family to the same physician when possible and appropriate.

Children and youth with special health care needs (CYSCHN) often require frequent visits with medical specialists or subspecialists. This should be taken into consideration when CYSHCN are linked to a personal physician.

> **AAP Guidance:** The AAP believes that any physician who can provide or coordinate all preventive, acute, and chronic care that a child needs can serve as the director of that child's medical home.

With respect to other health care professionals serving as the director of a child's medical home, the Academy continues to be guided by its policy statement, Scope of Practice Issues in the Delivery of Pediatric Health Care, which recognizes the valuable contributions of nonphysician clinicians, but retains the physician – preferably a pediatrician – as the director of a child's health care team.

AAP chapters with questions on scope of practice and the medical home should contact the Division of State Government Affairs at 800/433-9016 ext 7799 or stgov@aap.org.

Care Coordination

Care coordination is a hallmark of the medical home. Through care coordination, a physician's practice ensures that a patient accesses all essential health and human services across all elements of the health care system.

Registries, health information technology (HIT), and health information exchange (HIE) all enhance this coordination, involving medical specialists and surgical subspecialists, and public, private, and community-based providers of services.

There are different models and understandings of how care coordination is to function. In some medical home projects, care coordination is fully integrated within the physician's practice, sometimes with a care coordinator located in the practice. In others, care coordination is established outside the practice.

> **AAP Guidance:** The AAP recommends that care coordination be integrated into or provided within a physician's practice whenever possible. Programs with off-site care coordinators at the system/program level should supplement the care coordination provided in physician practices. Financing of care coordination should occur through a blended payment system, which recognizes each component of care provided in a medical home (see "Financing and Payment" section).

States may seek to further define the care coordination that takes place in a physician's office. This may entail the identification of a practice team or individual member of a practice team trained and skilled in managing patient care and providing care coordination services. States should ensure that all persons in a medical home pilot project are aware of their roles and expectations.

Care coordination is critically important for children and youth with special health care needs, who frequently need multiple professionals and agencies throughout the health care system. The medical home remains the optimal setting for family-centered care coordination for such children, to ensure that all care is centralized and information is shared, decreasing duplication of services and unnecessary care.

> **AAP Guidance:** States should consider the unique needs of children with special health care needs (CYSHCN) when designing medical home projects. States should consult the AAP policy statement, Care Coordination in the Medical Home: Integrating Health and Related Systems for Children with Special Health Care Needs to better understand the distinct needs of this population.

Enhanced Access

A hallmark of the medical home is that the child's medical home is continuously available and accessible to children and their families, with limited barriers to communication and care. It is

likely that medical home recognition programs in state medical home projects will emphasize enhanced access to care in physician practices.

AAP Guidance: The AAP recommends that enhanced access to a medical home include 24 hour/7 day per week coverage, after-hours care, open access scheduling, the provision of non-face-to-face care (telephone and email, telemedicine), and culturally appropriate language services for persons with limited English proficiency (LEP) or who are hearing- or vision-impaired. Medical home projects should also implement an established communication system for practices to receive information on care provided after-hours. Payment must be provided for all of these services.

Specifics may differ from state to state and project to project, but enhanced access should include expanded access to a variety of services. Payment should reflect the additional practice work necessary to provide this enhanced access.

Financing and Payment

Financing and payment for care provided in a child's medical home should recognize all of the additional support, care coordination, access, and services that are hallmarks of the medical home. General financing principles should be consistent across all medical home programs, including the concept of blended payments for services, as outlined in the AAP's policy statement, The Medical Home for Children: Financing Principles.

AAP Guidance: Payment for medical home services **must include all of the following:**

- A care coordination fee, which can be administered as a per member per month (PMPM) fee or as a summary payment, to be provided for the care coordination services of a physician's entire panel of program enrollees. This PMPM payment should be risk-adjusted to reflect the number and health status severity of CYSHCN in the practice or in the physician's panel.

- A contact- or service-based fee for the medical services provided to the child. This often occurs as a fee-for-service (FFS) payment. States may choose to enhance payments for specific types of services (eg, well-child care visits).

- A payment for quality improvement (eg, pay-for-performance/P4P, and infrastructure support.

States may additionally share savings generated by the medical home model with physician practices as a way to recognize practice efficiency. To improve efficiency, states may share HIPAA-compliant, practice-specific data with practices.

It is important to note that while management of a chronic condition may be a component of a medical home program, the medical home is not equivalent to disease management (DM)[1]. Moreover, while states may utilize Medicaid primary care case management (PCCM) program authority to facilitate PMPM payments, the medical home is not simply a PCCM system. Payments for quality of care improvements or other pay-for-performance (P4P) payments should be in addition to the payments for care provided in a medical home.

Of note, PMPM payments differ in value from state to state and medical home program to program. The AAP does not recommend a specific PMPM payment value, but urges states to consider the needs of physician practices and the wide scope of services that encompass care coordination in establishing rates. The Medicare program's medical home demonstration program (first authorized by the Tax Relief and Health Care Act of 2006, but currently on hold pending federal health care reform efforts) includes specific PMPM rates that are tiered by patient health status and reflect the complexity of coordinating care for enrollees in the Medicare program. These rates are available in the CMS Medical Home Demonstration Fact Sheet (see page 3, under "Monthly Medical Home Fees").

Infrastructure and Information Technology

A critical component of the medical home is the communication and successful transfer of patient information and health care data between physicians and other professionals, programs, and service agencies. Many physician practices will implement or expand their practice health information technology (HIT) infrastructure in order to better facilitate this transfer of information and data.

The American Recovery and Reinvestment Act of 2009 (ARRA) included passage of the HITECH Act, which will provide incentive payments to physicians participating in Medicare and Medicaid for the adoption and meaningful use of certified HIT. The HITECH Act also includes additional federal funds to states for the adoption of HIT Regional Extension Centers and for the creation of interoperable health information exchange (HIE).

The passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) also included significant new funding for children's health care quality. Included in the CHIPRA quality demonstration grants are grants specific to the development of a pediatric electronic health record format as well as other HIT activities. States working on or considering medical home projects should ensure that the development of

medical home HIT infrastructure is coordinated with other state HIT efforts.

AAP Guidance: The AAP believes that if use of health information technology (HIT) is required for practice participation in a medical home program, infrastructure payment should be made on the part of the state to support practice adoption of this HIT infrastructure. This payment should be separate from the HITECH Act or other outside HIT funding.

Practice education, coaching, and support

Practices implementing the medical home model may require education, coaching, and support to fully incorporate all the elements of the medical home, and to apply lessons learned and other best practices. States play a significant role in ensuring the expectations of enrollees, practices, and public and private programs are fully understood by all participating in a medical home model. States should provide ongoing aid to physician practices as they become full participants in a medical home project.

A number of states have formed multistakeholder demonstration sand have involved both public and private payers in learning collaboratives to spread knowledge of medical home implementation at the state, payer, and practice levels. These activities promote best practices and allow participants to collectively gain from sharing experiences.

AAP Guidance: States should support physician practices and other stakeholders in an ongoing fashion as the medical home project grows. This support should include technical assistance, the use of practice coaches (including those on-site), and facilitated learning collaboratives to spread knowledge, expertise, and best practices. States should place medical home project materials, data, and resources online so they can be easily referenced.

Enrollee education

To Medicaid, CHIP, and multistakeholder demonstration program enrollees participating in medical home programs, the term “medical home” may not have a specific meaning, or may add to an excess of health care terms that only complicate their understanding of the health care system. States play a critical role in explaining the state’s medical home program and expectations of all involved in the program, including enrollees and their families. This can include various forms of patient education, including marketing materials, patient coaching, eliciting the support of community-based organizations, and online support materials, among others.

AAP Guidance: It is critical that medical home program enrollees and their families fully understand their roles and responsibilities within the medical home project. States play a significant role in educating patients and their families as to the medical home model and how practices will coordinate care among various health care sites and programs. States should provide ongoing support to enrollees and families in an effort to better understand the medical home program. States should allow physician practices to educate patients and their families as to practice-specific enrollee requirements.

States should consult the 2009 PCPCC Consumer Guide for examples of state efforts to engage consumers. Families should consider using the AAP Care Notebook to maintain an ongoing record of their child's care, services, health care professionals, and notes. Practices should also consider offering a Web portal and offering/suggesting an electronic personal health record to their patients.

Community system engagement and program education

The medical home involves countless health care professionals and components of the health care, educational, and human service systems. Implementation of a medical home project within a state Medicaid or CHIP program will involve increased coordination between pediatricians and other health care professionals, and state, community, and private programs and services. Therefore it is critical that state, community, and private programs and services interacting with the medical home understand the medical home model and how patient information is to be shared among the various facets of the health care system.

AAP Guidance: State Medicaid, CHIP, and multistakeholder demonstration programs must play an active role in engaging state, community, and private programs and services that will be interacting with medical homes in the medical home project. States should educate these programs and service providers as to their roles and expectations in the project, and how patient information is to be shared with the medical home. State policies should facilitate communication between partners/stakeholders across various systems (eg, mental health, oral health, Title V, etc).

Care transitions for children

Unlike adults, children will eventually transition from a pediatric-focused health care system to that of adults. During this critical time, it is important that adolescents and their families become acclimated to the adult health care environment, and fully understand different requirements and practices of insurance coverage as well as professionals and programs with which they will be interacting. Transition is of unique importance to children

with special health care needs, as a successful and timely transition ensures that healthy development continues and that the patient's functioning is optimized.

Successful transition involves ensuring all needs of an adolescent enrollee are met in the adult health care system. State programs play a role in ensuring a smooth and well-timed transition to the adult health care world.

AAP Guidance: State medical home projects should include transition planning for adolescent children entering the adult health care system. Policies should facilitate communication between child and adult systems to ensure successful transition. Special attention should be paid to children with special health care needs. States are encouraged to look to the AAP policy statement, A Consensus Statement on Health Care Transitions for Young Adults With Special Health Care Needs, of the American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians – American Society of Internal Medicine for guidance.

Ongoing family involvement

The medical home seeks to best address the needs of patients and their families in a collaborative, ongoing fashion. Therefore, it is vital that state programs and practices continue to involve families in the planning and implementation of medical homes, to ensure medical homes continue to meet families' needs.

AAP Guidance: State medical home advisory committees should include families, which should be consulted as to the impact of state medical home changes. Practices adopting the medical home model should create practice-level family advisory committees that meet on a regular basis to ensure the practice continues to meet families' needs.

Program measurement

The medical home model seeks to improve patient care and maximize efficiencies in the health care system. Measuring programmatic impact is important in documenting the positive influence the medical home model has both on outcomes, patient satisfaction, and the health care system itself. State medical home projects should invest resources to ensure that programs are appropriately evaluated.

AAP Guidance: States should implement a comprehensive evaluation of its medical home project, including both **qualitative** measures as to quality of care and patient and health care professional satisfaction, as well as **quantitative** measures of impact on health measures, utilization, and program costs.

Examples of possible performance measurement sets include:

- Healthcare Effectiveness Data and Information Set (HEDIS) measures
- Medicare's Physician Quality Reporting Initiative (PQRI) measures
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures
- The new pediatric quality measures program – authorized by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) – to be released in 2010

States should disseminate the results of such studies to all interested parties, to inform the ongoing implementation and expansion of the project, and to further best practices among medical home projects across the country.

Resources

National Center for Medical Home Implementation
American Academy of Pediatrics
http://www.medicalhomeinfo.org/

Building Your Medical Home Toolkit
National Center for Medical Home Implementation
American Academy of Pediatrics
http://www.pediatricmedhome.org/

Joint Principles of the Patient-Centered Medical Home
http://www.medicalhomeinfo.org/downloads/pdfs/JointStatement.pdf

Measuring Medical Homes: Tools to Evaluate the Pediatric Patient- and Family-Centered Medical Home
http://www.medicalhomeinfo.org/downloads/pdfs/MonographFINAL3.29.10.pdf

AAP Index of CPT Codes for Medical Home
http://www.medicalhomeinfo.org/downloads/pdfs/MedicalHomeCodingFactSheet.pdf

AAP Care Notebook
http://www.medicalhomeinfo.org/for_families/care_notebook/

Medical Home State Data Pages
Child and Adolescent Health Measurement Initiative (CAHMI) Data Resource Center (DRC)
http://medicalhomedata.org/content/Default.aspx

Making Medical Homes Work: Moving from Concept to Practice,
Center for Studying Health Systems Change - December 2008.
http://hschange.org/CONTENT/1030/?words=medical+home/

Continuous Innovation in Health Care: Implications of the Geisinger Experience
Health Affairs, September 10, 2008.
http://www.commonwealthfund.org/Content/Publications/In-the-Literature/2008/Sep/Continuous-Innovation-in-Health-Care--Implications-of-the-Geisinger-Experience.aspx

Incremental Cost Estimates for the Patient-Centered Medical Home
Commonwealth Fund, October 16, 2009.
http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Oct/Incremental-Cost-Estimates-For-The-Patient-Centered-Medical-Home.aspx

Medical Home Page
National Academy for State Health Policy (NASHP)
http://www.nashp.org/node/28

Medical Home Publications
NASHP
http://www.nashp.org/nashp-pubs/28

Medical Home State Scan, November 2008
NASHP
http://www.nashp.org/sites/default/files/medical_home_scan_Nov_2008.xls (Excel file)

Medical Home State Map
NASHP
http://www.nashp.org/med-home-map

Webinar: State Roles in Multipayer Medical Home Pilots
NASHP
http://www.nashp.org/sites/default/files/combined_slides.pdf

Webinar: Strategies States Use to Support the Infrastructure of a Medical Home
NASHP
http://www.nashp.org/sites/default/files/PCMH_Infrastructure_April2.pdf

Webinar: Supporting the Patient-Centered Medical Home in Medicaid & SCHIP: Savings and Reimbursement
NASHP
http://www.nashp.org/sites/default/files/PCMH_Savings_Reimbursement_March6.pdf

Physician Practice Connections-Patient-Centered Medical Home (PPC-PCMH)
National Committee for Quality Assurance (NCQA)
http://www.ncqa.org/tabid/631/default.aspx

2009 Medical Home Presentations
National Governors Association (NGA)
http://www.subnet.nga.org/center/meeting/

Patient Centered Primary Care Collaborative (PCPCC)
http://www.pcpcc.net/

Evidence of Quality
PCPCC
http://pcpcc.net/content/evidence-quality

Purchaser Guide
PCPCC
http://pcpcc.net/content/purchaser-guide

2009 Consumer Guide
PCPCC
http://pcpcc.net/consumer-guide/

2009 Pilot Guide
PCPCC
http://pcpcc.net/pilot-guide/

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http://pediatrics.aappublications.org/cgi/content/full/113/5/S1/1493

Strickland B, Singh G, Kogan M, et al. **Access to the Medical Home: New Findings From the 2005-2006 National Survey of Children With Special Health Care Needs.** *Pediatrics.* 123(6):2009. Accessed January 2010.
http://pediatrics.aappublications.org/cgi/content/abstract/123/6/e996

[1] "Disease management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant." DMAA: The Care Continuum Alliance. DMAA definition of disease management. Available at: http://www.dmaa.org/dm_definition.asp. Accessed January 30, 2010.