WHAT MAKES A MEDICAL HOME?

This model is beneficial for children and youth who have complex health care needs. The provider partners with the patient and family to coordinate the patient’s care with all of the others involved—such as specialists, schools, and community organizations. The goal is to deliver the best possible care to the patient in a coordinated fashion. Key features of a Medical Home practice are:

1. ACCESSIBLE: It is easy for the patient and family to get appointments, referrals, and services. The medical team spends enough time with each patient to understand and address all needs.

2. FAMILY-CENTERED: Medical decisions are made WITH the family—respecting their wants, needs, and preferences. A Medical Home recognizes that parents/caregivers are the expert in their child’s care.

3. CULTURALLY COMPETENT: The providers have a sensitivity to differences in culture, language, beliefs, and traditions of the family. These differences are recognized, valued, and respected.

4. CONTINUOUS: The same medical team cares for the patient until they transition to adult care. The provider and patient/family learn about and respect each other. Continuity of medical team members is ideal for monitoring patient care. Medical Home providers facilitate smooth transitions from hospital to home and/or outpatient and from infant care through transition to adulthood.

5. COMPREHENSIVE CARE: All providers work as a team to meet the patient’s needs, including prevention, wellness, acute, and chronic care. Staff make referrals and connections to additional resources.

6. CARE PLAN: A tool to help understand the “big picture” of the patient’s supports. It is created in partnership with the family and shows the entities involved in the patient’s care and support. The care plan describes the roles of each clinician, agency and organization in providing coordinated services and supports to deliver medical care in ways that are based upon the Medical Home concepts.

7. CARE COORDINATION: A Care Coordinator may facilitate meetings of the Care Team (those who care for the patient’s comprehensive needs), help with the development, revisions, and implementation of a Care Plan, and to manage transitions. They may assist with scheduling appointments, ordering supplies, or connecting the family with other providers, agencies and organizations.
WHY SHOULD YOU WANT OR SEEK A MEDICAL HOME?

Beyond just asking if the practice follows a Medical Home model, consider asking additional questions:

- What does Medical Home look like in your practice?
- What is different because you follow this model?
- Do you have an individual who supports families in Care Coordination?
- Will we see the same provider at each visit?
- What are your office hours? How can I access the practice after hours?
- Do you have parent partners or advisers?
- Does anyone in the practice support transition from inpatient to outpatient and into adult oriented systems?

Perhaps you cannot locate a Medical Home practice or your child/youth is already seeing a doctor who does not follow the Medical Home model.

What steps can you take to begin to build medical home idea into your child’s practice?

1. Visit the PA Academy of Pediatric Medical Home website to learn more about the hallmarks of Medical Home.
2. Share material, websites, or stories about the benefits of Medical Home concepts.
3. Talk to the medical team about elements of Medical Home that would be beneficial.
4. If your child's practice applies the concepts of the Medical Home but does not have certification, encourage them to become a recognized medical home practice.

For more information or to schedule a presentation:

- See [www.pamedicalhome.org](http://www.pamedicalhome.org)
- Email: pamedicalhome@paaap.org
- Follow: [www.facebook.com/pamedicalhome](http://www.facebook.com/pamedicalhome)
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