135.158 Medical home purposes — characteristics.

1. The purposes of a medical home are the following:

a. To reduce disparities in health care access, delivery, and health care outcomes.

b. To improve quality of health care and lower health care costs, thereby creating savings to allow more Iowans to have health care coverage and to provide for the sustainability of the health care system.

c. To provide a tangible method to document if each Iowan has access to health care.

2. A medical home has all of the following characteristics:

a. A personal provider. Each patient has an ongoing relationship with a personal provider trained to provide first contact and continuous and comprehensive care.

b. A provider-directed team-based medical practice. The personal provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing health-related needs of patients.

c. Whole person orientation. The personal provider is responsible for providing for all of a patient's health-related needs or taking responsibility for appropriately arranging for health-related services provided by other qualified health care professionals and providers of medical and nonmedical health-related services. This responsibility includes health-related care at all stages of life including provision of preventive care, acute care, chronic care, long-term care, transitional care between providers and settings, and end-of-life care. This responsibility includes whole-person care consisting of physical health care including but not limited to oral, vision, and other specialty care, pharmacy management, and behavioral health care.

d. Coordination and integration of care. Care is coordinated and integrated across all elements of the complex health care system and the patient's community. Care coordination and integration provides linkages to community and social supports to address social determinants of health, to engage and support patients in managing their own health, and to track the progress of these community and social supports in providing whole-person care. Care is facilitated by registries, information technology, health information exchanges, and other means to assure that patients receive the indicated care when and where they need and want the care in a culturally and linguistically appropriate manner.

e. Quality and safety. The following are quality and safety components of the medical home:

(1) Provider-directed medical 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 providers, the patient, and the patient's family.

(2) Evidence-based medicine and clinical decision-support tools guide decision making.

(3) Providers in the medical practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

(4) Patients actively participate in decision making and feedback is sought to ensure that the patients' expectations are being met.

(5) Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

(6) Practices participate in a voluntary recognition process conducted by an appropriate nongovernmental entity to demonstrate that the practice has the capabilities to provide patient-centered services consistent with the medical home model.

(7) Patients and families participate in quality improvement activities at the practice level.

f. Enhanced access to health care. Enhanced access to health care is available through systems such as open scheduling, expanded hours, and new options for communication between the patient, the patient's personal provider, and practice staff.

g. Payment. The payment system appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure framework of the medical home provides all of the following:

(1) Reflects the value of provider and nonprovider staff and patient-centered care management work that is in addition to the face-to-face visit.

(2) Pays for services associated with coordination of health care both within a given practice and between consultants, ancillary providers, and community resources.

(3) Supports adoption and use of health information technology for quality improvement.

(4) Supports provision of enhanced communication access such as secure electronic mail and telephone consultation.

(5) Recognizes the value of provider work associated with remote monitoring of clinical data using technology.

(6) Allows for separate fee-for-service payments for face-to-face visits. Payments for health care management services that are in addition to the face-to-face visit do not result in a reduction in the payments for face-to-face visits.

(7) Recognizes case mix differences in the patient population being treated within the practice.

(8) Allows providers to share in savings from reduced hospitalizations associated with provider-guided health care management in the office setting.

(9) Allows for additional payments for achieving measurable and continuous quality improvements.

2008 Acts, ch 1188, §45; 2013 Acts, ch 138, §175, 187

Referred to in §135.157, §135.159