

**Recommendations for the Adoption of Standards
Patient Centered Medical Homes in Medically Underserved Areas
Community Health Care Homes**

1. In addition to the adoption of NCQA standards for a Patient Centered Medical Home, complimentary standards should be established for those "medical homes" located within federally designated Medically Underserved Areas (MUAs) or for those medical homes serving Medically Underserved Populations (MUPs). These Patient Centered Medical Homes that meet these complimentary standards should be recognized as "Community Health Care Homes."
2. The Community Health Care Home should meet additional standards in four areas of competence: Community Participation, Training and Economic Development, Cultural Practices, and Enabling Services. (Examples of such complimentary standards are listed starting on page 2.)
3. A formal process of developing specific measures of competency for each of these standards should be driven by the consumer board members of potential community health care homes. (See "Journey to an Island Healthcare Home" conference findings in attachment A). It is suggested that the consumer board infrastructure of the National Association of Community Health Centers take the lead in this process.
4. A Community Health Care Home shall either be a community based network or a single site provider of comprehensive health care services and shall include at a minimum primary medical care, dental care, behavioral health services, prevention and education services, and advanced care management and other enabling services. When these services are provided at multiple sites specific standards for accessibility of these services shall be developed. Referral standards and protocols for the entire continuum of medical care services should also be in place.
5. Enabling service standards should be based on the delivery, codification and tracking of enabling services referenced in the "Handbook for Enabling Services Data Collection" by the Association of Asian and Pacific Community Health Organizations and in the National Association of Community Health Centers/MGMA report on enabling services.
6. Standards for the Patient Centered Medical Home and the Community Health Care Home should address the original principles of the medical home established by the American Academy of Pediatrics and should promote services that are: community based and accessible, family centered, coordinated, comprehensive, continuous, culturally effective and compassionate.
7. Pay for Performance incentives may be used within the Community Health Care Home model provided that these performance measures address unique population characteristics, reflect mutually agreed upon metrics chosen by both the payer and the community health care home, are updated regularly, and

should, as one element, measure comprehensive health care service process rather than just medical outcome or process.

Note: Nothing in the recommendations listed below should prohibit networks of medical providers and other community agencies to form networks to meet the Community Health Care Home (CHCH) criteria.

Examples of standards that could be used to address the four Community Health Care Home areas of competence:

Community Participation

Has a panel of patients reviewed and approved an annual plan that identifies health care needs or disparities within the CHCH community and established an action plan to address these issues?

Has the community panel or board been provided adequate data to measure CHCH performance in promoting access, quality and cost effectiveness?

Is there a systematic process in place for measuring patient satisfaction and performing any remedial action?

Training and Economic Development

Have efforts been made for the CHCH to train and hire health care workers from the CHCH's service area?

Is there an accessible on the job training program for CHCH workers hired from the service area to improve job competencies?

Do job training activities include training in the use, support for, and development of Health Information Technology?

Cultural Practices

For a CHCH that serves a multi-cultural population, is a panel of cultural advisors engaged in developing and evaluating cultural practices?

Are cultural protocols established in CHCH policies and procedures?

Are CHCH employees provided an orientation into the policies and procedures identified above?

Enabling Services

Does the (CHCH) track enabling services using standardized enabling service codes?

Does the CHCH use advanced care management practices identified by AAPCHO codes CM001 (Case Management Assessment), CM002 (Case Management Treatment Facilitation), CM003 (Case Management Referral)?

Does the CHCH screen uninsured patients for Medicaid or other insurance eligibility and assist the patient with enrollment in available coverage?

Does the CHCH identify and profile the reasons uninsured patients are denied Medicaid coverage?

Are the needs for transportation, translation and literacy assistance identified in the medical record and provided?

Is there referral to any indicated (by best practice protocols) health education, dietary services, exercise or behavioral health services and are these services codified and tracked in the medical record?