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California Pan-Ethnic Health Network

HOW MEDICAL HOMES CAN ADVANCE HEALTH EQUITY

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The California Pan-Ethnic Health Network

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Authored by:
Ignatius Bau, JD

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With the implementation of national health care reform over the next few years, attention will increasingly shift from access to health insurance to the quality of care provided. It will be critical for communities of color to be engaged in developing and evaluating models for improving the quality of care to ensure that equity is addressed. There are several models of "patient-centered medical homes" (also being referred to as "patient-centered health care homes," "primary care homes," "advanced primary care practice," or "health home services") that have emerged as potential pathways to quality improvement. The Patient Protection and Affordable Care Act (PPACA) provides additional funding and support for these models of health care delivery, reinforcing their importance as a concept for redesigning the delivery system and improving quality of care. This issue brief describes the various medical home models and highlights the characteristics of medical homes that could advance health equity and are especially relevant for communities of color and other underserved communities.

WHAT IS A MEDICAL HOME?

The concept of a medical home has been used as a model for coordinating and improving health care for nearly fifty years (a brief history is provided on page 12). At its core, it is a model for health care delivery that highlights the importance of primary care, an ongoing relationship of trust and communication with a physician, proactive coordination of care with other health professionals as part of a care team, active patient engagement and partnership in optimizing the patient's health and well-being, a comprehensive and whole-person perspective on health that is not limited to physical health or just one condition or disease, and ultimately, demonstrable improvements in health care quality and health status from evidence-based medicine.

THROUGH A PATIENT'S EXPERIENCE: IMPROVED CARE THROUGH A MEDICAL HOME

You are a Latina with diabetes. You work and take care of your family (which includes a husband, two children, and your mother who lives with you) so your diabetes is not the only issue in your life. Your medical home helps you manage your disease and maintain your health as well as you can. You trust your physician because she and most of her staff speak Spanish. You liked the fact that the first time you had an appointment with your physician she did a comprehensive health assessment, explained all of the services she and her staff at the "medical home" are able to provide, and asked you to agree to a "care plan," with personalized monthly goals for managing your diabetes and improving your health. She also asked about your family and encouraged both your husband and mother to have a similar medical home to make sure they take care of their health. She knew the pediatrician taking care of your children and asked if you wanted her to share information about your family's health with the pediatrician so that all your family's health care might be better coordinated.

One of the services you have been able to use is the nutritionist on the staff at your medical home, who provides useful information about how to prepare traditional Mexican meals that are healthier for you and your family but don't take more time or cost more. You are able to schedule appointments with your physician either at her office (she has office hours during some evenings and on weekends), or through a telephonic "visit" when she reviews your care plan, your medications, and talks about what else is happening in your life that might impact your health. Your medical home sends reminders (in Spanish) for your appointments by text messages to your mobile phone. After each visit to your physician's office or telephonic visit, you receive a summary (in Spanish and English) about the visit, with your updated care plan and medication list. You get this as a print out at the physician office (or by mail after a telephonic visit). You also get your updated medication list as a text message so you have it available on your mobile phone.

Your medical home sends you reminders by text message to refill your prescriptions when your supply is close to running out. You can order refills either through an automated telephone service (available in Spanish) or through your medical home's internet website (also available with instructions in Spanish). Your brother has internet access at his house so sometimes you check your medical home's website when visiting him. When you do access the website, you are able to download brochures, recipes, videos, and other educational materials about diabetes (all in Spanish). You have found these resources useful and shared them with other family members and friends.

While the models – and the specific terminology – continue to change and evolve, there are ten common characteristics of most of the current medical home models. A medical home is a primary care provider who:

1. Develops a ***provider-patient partnership***.
2. Ensures ***access and communication*** with the provider in person, by phone, and electronically.
3. Provides ***comprehensive primary care services***, including health promotion, preventive services, and care management.
4. Uses ***electronic health record systems*** to document (and make available) clinical information, monitor patient registries, facilitate clinical decision support, and generate alerts and reminders.
5. Uses ***electronic prescribing*** and conducts ***medication reconciliation***.
6. ***Tracks and follows up*** on tests.
7. Tracks and follows up on referrals to specialists and community resources and ensures ***coordination of care***, especially during transitions of care.
8. Supports ***patient engagement*** and self-management.
9. Provides the patient with ***access to health information*** in multiple formats.
10. Measures and reports on quality, including patient experiences, and implements ***quality improvement interventions***, including disparities reduction.

The next section describes each of these characteristics and highlight how they could advance health equity for communities of color and other underserved patient populations.

HOW MEDICAL HOMES CAN ADVANCE HEALTH EQUITY

Physician practices, community health centers, and other primary care providers that implement medical home models can simultaneously advance health equity by paying particular attention to the characteristics of medical home models highlighted below. In some cases, these characteristics are already features of safety net providers such as community health centers. On the other hand, additional development, innovation, and advocacy are needed to ensure that these optimal opportunities for advancing equity are included in the development and implementation of medical homes.

1) Develops a provider-patient partnership

In a medical home, patient engagement and partnership is explicitly encouraged and supported by the physician and the rest of the staff. There is an increasing recognition that a physician cannot, and often may not be the best trained professional, to provide all the care and services that a patient needs for optimal health and well-being. Most medical home models encourage delegation of responsibilities to other members of a health care team. For many patients, the explanation of the medical home and partnership will need to include the patient's family and caregivers.

Opportunities to Advance Equity: Any explanation about and agreement with a patient to participate in a medical home should be done in a culturally and linguistically appropriate way. Even if a patient can communicate effectively in English, the patient's family and caregivers may need language assistance services for there to be an informed partnership. Increased engagement of patients, families, and caregivers, especially those with linguistic and cultural barriers to care, will improve the quality of care. By proactively and explicitly engaging a patient's family and caregivers in developing the partnership with the medical home, the patient's cultural beliefs and values are respected and care instructions are more likely to be understood and followed.

To advance equity, medical homes should intentionally recruit and retain members of the health care team from the local community, reflecting the diverse patients served. These members of the health care team can be instrumental in building trust, rapport, and effective partnerships between the medical home and diverse patients, families, and caregivers.

2) Ensures access and communication with the provider in person, by phone, and electronically

At the core of a medical home is access to health care when the patient needs and wants it. That means traditional visits to one's physician's office but it will also increasingly mean scheduling "telephonic visits" or exchanging e-mail messages with the physician or members of her medical team. Phone advice staffed by nurses 24 hours a day, seven days a week will likely replace physician office after-hours message services. An authentically "patient-centered" medical home would redefine "routine office hours" and make what is now

considered "after hours" access – evenings and weekends – the "routine." This will be particularly important to patients who have work, child care, and other responsibilities during today's "routine office hours" and have to take time off or find others to assume their responsibilities in order to access care.

Opportunities to Advance Equity: In order for there to be comprehensive access to one's medical home, language assistance services should be available at the physical site of care and through any telephonic care and advice services. Bi-directional multilingual communications should be available (e.g., ability to send a telephone, e-mail, or text message to one's provider in a language other than English, and receive messages in languages other than English). Ensuring language access will improve access to care and the quality of care provided to patients with limited English proficiency. Finally, with all of the new and complex rules for eligibility for new health care insurance products under the PPACA, medical homes should provide proactive assistance with eligibility, enrollment, and retention in public insurance programs.

3) Provides comprehensive primary care services, including health promotion, preventive services, and care management

All medical home models are built on the promise of truly comprehensive primary care, including prevention. A medical home physician will be providing or coordinating all of the patient's care, including health promotion, preventive services, and care management. The medical home will use a "whole person" orientation to provide care, rather than only responding to a specific diagnosis or condition. The goal will be optimizing the patient's health outcomes and health status, rather than just providing health care when the patient is "sick."

Many safety-net providers, especially community health centers and family physicians, already provide comprehensive family-based primary care (e.g., families can choose the same provider and have appointments for family members on the same day). In addition, many community health centers are already models for integrated care. For example, there are community health centers that provide integrated oral, mental, and behavioral health care, as well as having on-site lab, imagining, and pharmacy services. Some of them also have strong health promotion and disease prevention programs, often using community health workers, and even provide complementary and alternative medicine services.

Opportunities to Advance Equity: The comprehensiveness of health care services currently provided by many community health centers is an element that should to be highlighted, encouraged, and reimbursed as ideal patient-centered medical homes, where there is "one-stop" availability of health services rather than requiring multiple appointments at multiple sites (which is inconvenient for the patient and requires coordination among the providers).

Medical homes should conduct comprehensive health assessments which should include questions about the support that is provided or needed from the patient's family and caregivers. Any care management (or disease management or case management) provided by a medical home should be culturally and linguistically appropriate, and utilize evidence-based and best practices for care management for diverse patient populations.

4) Uses electronic health record systems to document (and make available) clinical information, monitor patient registries, facilitate clinical decision support, and generate alerts and reminders

Every medical home model will depend on health information technology (HIT). With the availability of incentive payments through Medicare and Medicaid to physicians for the "meaningful use of certified HIT" under the Health Information Technology for Clinical and Economic Health (HITECH) Act, requirements for medical homes are expected to be aligned with and build from the requirements for "meaningful use" to be eligible for those incentive payments. One of the great promises of electronic health records is improved (more accurate and comprehensive) documentation of clinical information (diagnoses, current and past vital signs, test results, treatment plans, medication, etc.). Moreover, the electronic health record can "support" the provider's clinical decisions with electronic reminders, alerts, and references to clinical guidelines, new evidence, medication interactions, and other tailored, real-time information. Similarly, the electronic health record can prompt the provider to (or automatically) generate reminders and alerts to the patient (to follow-up on a test, refill medications, return for an office visit, etc.) through patient registry functions. All of these tools will improve the quality of care provided by medical homes.

Opportunities to Advance Equity: Unless these clinical decision support systems reference and consider race, ethnicity, and language data, disparities may be overlooked or even perpetuated (a reminder sent in English to a limited English proficient patient will not be effective). Moreover, clinicians who see a higher number of patients with some conditions (e.g., Asian American patients at risk for hepatitis B) may want to develop additional, more proactive, electronically-supported clinical guidelines for conditions more prevalent in their specific patient populations.

5) Uses electronic prescribing and conducts medication reconciliation

With the expected widespread implementation of health information technologies, medical homes will be required to use electronic prescribing and conduct electronically-supported medication reconciliations at transitions of care (e.g. making sure the list of medications a patient is using is updated upon discharge from the hospital). The use of these health information technologies will reduce errors and improve patient safety, increasing the quality of care.

Opportunities to Advance Equity: Language needs should be communicated to pharmacies as part of the electronic prescription. Medication lists and instructions should be available to patients, families, and caregivers in multiple languages and in formats that address health literacy and disability barriers. Having patients, families, and caregivers engaged in understanding the prescribed use of medication will reduce medication errors, improve patient safety, and improve outcomes and quality. Medication reconciliations should be conducted with language assistance services to ensure the participation of the patient, families, and caregivers.

6) Tracks and follows up on tests

Another responsibility of medical homes will be to track and follow-up on lab and imaging tests to ensure updated clinical information and minimize duplication.

Opportunities to Advance Equity: Medical homes can reduce health disparities by ensuring that referrals to testing facilities alert them to the language and cultural needs of their patients, and that test instructions and results are available in multiple languages and in formats that address health literacy and disability barriers.

7) Tracks and follows up on referrals to specialists and community resources and ensures coordination of care, especially during transitions of care

Although medical homes are focused on primary care, they will be required to proactively coordinate other care, including specialty care. With health information technologies, there will be an increased standardization of electronic "care coordination documents" – referrals and follow-up instructions to ensure communication, exchange of health information, and optimal coordination among providers. Moreover, there may be prevention, education, or other social services that would support a patient's health and well-being that require linkages to community resources and services.

Opportunities to Advance Equity: To address and reduce health disparities, care coordination documents should be available to patients, families, and caregivers in multiple languages and in formats that address health literacy and disability barriers. Emerging state and regional health information exchanges will facilitate the electronic exchange or access to clinical health information among multiple providers. Medical homes should provide race, ethnicity, and language data about patients in such electronic exchanges of health information to avoid duplicative questioning of the patient and to ensure culturally and linguistically appropriate services at all points of care.

Medical homes should proactively identify and develop formal referral agreements with culturally and linguistically appropriate health education and support services; home health, adult day health, and rehabilitation facilities; schools and child care centers; and other programs and services. Most community health centers already provide many of these types of services as "enabling services." Finally, medical homes should conduct continuous advocacy with local and state health, social services, and aging departments, and school districts for culturally and linguistically appropriate services for their patients, families, caregivers, and communities.

8) Supports patient engagement and self-management

The "patient-centered" elements of medical homes will require increased patient engagement and use of patient self-management tools. In order for these tools to be authentically patient centered, patients themselves must be active in their development and evaluation.

Opportunities to Advance Equity: Very few of the patient engagement tools currently available are culturally and linguistically appropriate. In order for medical homes to be utilized effectively by diverse patient populations, culturally

and linguistically appropriate shared decision making tools, group visit protocols, peer-based care management support, patient self-management tools (and those for families and caregivers) must be developed, evaluated, and implemented. Many community health centers already use innovative mechanisms for patient input and engagement through representation on their boards of directors, patient advisory councils, and patient/member/community meetings. These types of patient engagement need to be developed for all medical homes.

9) Provides the patient with access to health information in multiple formats

To support provider-patient partnerships, improve care coordination, and foster patient engagement and self-management, medical homes will be required to provide their patients with increased access to their health information. For example, medical homes will be required to provide either electronic copies or electronic access to clinical summaries and other health information.

Opportunities to Advance Equity: To reduce health disparities, the clinical summaries and other health information, in addition to personal health records, should be available to patients, families, and caregivers in multiple languages and in formats that address health literacy and disability barriers.

Some medical home models require internet access for patients to secure their health information. These internet websites should enable bi-directional multilingual communication and address literacy and disability barriers. Furthermore, given the continuing digital divide in internet availability among certain racial and ethnic minorities, low-income individuals, seniors, and those in rural areas, medical homes should use mobile phone and other mobile devices for bi-directional communication and access to electronic health information.

Finally, with the increased reliance on health information technologies, it will be essential that all patients understand and consent to the use of electronic health information through a culturally and linguistically appropriate consent process.

10) Measures and reports on quality, including patient experiences, and implements quality improvement interventions, including disparities reduction

Medical homes will be required to measure and report on clinical quality outcomes. In addition, there will be increasing requirements for medical homes to include patient experiences as part of their quality reporting. Medical homes will also be required to demonstrate specific improvements in quality.

Opportunities to Advance Equity: All quality measures should be analyzed and reported with stratifications by race, ethnicity, and language. Patient experience surveys must be culturally and linguistically appropriate and multiple, culturally appropriate, data collection methods such as patient focus groups and key informant interviews with community leaders should be encouraged. Medical homes can be more authentically patient centered by engaging diverse patients, families, and caregivers in staff training, and using diverse patient advisors for all quality improvement activities, including analyses of quality data and evaluation of the effectiveness of quality improvement efforts. Medical home quality improvement activities should explicitly include interventions to reduce identified disparities. Evaluation and progress on disparities reduction should be measurable and reported in a transparent process.

The characteristics of medical homes described above are particularly relevant for patients and health consumers in communities of color, who often experience the greatest health care disparities. By building these characteristics into the implementation of medical homes, health care providers can advance equity while improving the overall quality of care. The following sections describe the origins and evolution of the medical home models.

THROUGH A PATIENT'S EXPERIENCE: IMPROVED CARE THROUGH A MEDICAL HOME

You are a single African-American father raising your 11-year old son, who has asthma. Your child's medical home physician has worked with you and your son over time to develop a customized asthma care plan, including explaining and monitoring the different medications your son needs. When you take your son to his physician's office, they give you a handheld tablet computer (such as an iPad), which asks you to verify all your demographic and insurance information, and then report on asthma symptoms and any other changes in health since your son's last visit. Then, while you are waiting to see the physician, the computer plays a video tailored for young African-American children about asthma and the importance of taking the control medication regularly (you also are able to download the video from the physician's internet website). Although you are not particularly technologically savvy, you find this registration process easy to use, and your son really likes the opportunity to use the computer. During each visit, the physician reviews your son's care plan and talks with your son about his symptoms and how he is doing in school.

All the prescriptions for your son are sent electronically to your local pharmacy. At an initial visit, the physician helped you identify which pharmacy would be the most convenient for you and would offer the lowest prices for all of the medications, based on your insurance plan's prescription drug coverage. At subsequent visits, the physician verifies that this pharmacy is still the best choice for you and reminds you when you should refill the prescriptions. During this visit, the physician also encourages your son to do more physical activity. Together you decide to add participation in a free hip-hop dance class offered by the local YMCA to your son's care plan.

Unfortunately, two months later, you have to take your son to the emergency department in the middle of the night because of a severe asthma attack. The hospital immediately notifies his physician who comes to visit your son the next morning, before your son is discharged from the hospital. Upon discharge, you are given a written summary about the emergency admission and an updated medication list. The physician schedules a follow-up visit at his office a week later.

When you take your son for the follow-up visit, the physician reviews your son's care plan and medications and asks about what might have triggered the latest attack. He offers to send a nurse to your home to do an environmental assessment of potential asthma triggers. When the nurse conducts the home visit, she helps identify and explain potential triggers such as dust and mold. She refers you to a local legal services agency that works with you to get your landlord to replace the very old carpets in your apartment and re-paint the moldy bathroom walls. The nurse continues to work closely with the lawyer and keeps the physician updated on your situation. Your son seems to be doing well for now, and you look forward to having the triggers removed from your apartment. You have been discussing your situation with some of your friends at church who also have children with asthma and they are interested in working with your lawyer and their physicians on getting similar changes made in their apartments.

BRIEF HISTORY OF MEDICAL HOMES

As mentioned above, the concept of medical homes has been around for almost fifty years and is still evolving. Understanding how it started can help us influence the future of medical homes.

Origin: Medical Homes for Children with Special Needs

The concept of a "medical home" was first developed in the late 1960s for children with special health needs, who often require a greater degree of care coordination with specialist physicians, developmental specialists, rehabilitation services, educational services, and other social services. The core idea was that a primary care physician (usually a pediatrician or family medicine physician) needs to be aware of, and proactively coordinate, all the care that child needs, in partnership with the child's parents, family, and caregivers. There was recognition that while each specialist or other service provider was essential for supporting the health and well-being of the child, there was a unique role for one physician to be the "home," or primary coordinator of all that care.

ACCORDING TO THE JOINT PRINCIPLES, A MEDICAL HOME HAS THE FOLLOWING ELEMENTS:

- Ongoing relationship with a personal physician for first contact, continuous, and comprehensive care
- Personal physician leads team of providers for ongoing care
- Whole person orientation and provision of acute, chronic, preventive, and end of life care
- Care is coordinated and integrated, facilitated by registries, health information technology and health information exchange, and assures that patients get indicated care when and where they need and want it in a culturally and linguistically appropriate manner
- Quality and safety, supporting optimal, patient-centered outcomes, use of evidence-based medicine and clinical decision support tools, continuous quality improvement, patient participation in decision making and feedback, and information technology
- Enhanced access to care
- Payment recognizes added value provided to patients

Physician Association Medical Home Models

Physician associations began developing models of medical homes for other patient populations, in addition to children. In 2004, the American Academy of Family Physicians (AAFP) called for every American to have a "personal medical home" and has been working primarily through its subsidiary TransforMED to promote the concept and to provide technical assistance to its members on implementation. In 2006, the American College of Physicians (ACP) developed a policy monograph on medical homes and a year later, the AAFP and ACP, along with the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA), joined together to issue "Joint Principles for a Patient-Centered Medical Home," which created new interest and momentum for advancing the concept. The Joint Statement uses the following definition of a medical home:

The patient-centered medical home is an approach to providing comprehensive primary care for children, youth, and adults. The patient-centered medical home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

CURRENT EFFORTS TO PROMOTE MEDICAL HOMES

The evolution of the medical home model has provided the field with a foundation on which to build. More recently, there has been increased attention and momentum promoting the use of medical homes and with the passage of the HITECH Act and Patient Protection and Affordable Care Act, there are even greater incentives to restructure our health care delivery system. These efforts represent a unique opportunity for health professionals, advocates, and community leaders to play a critical role in influencing how medical homes are defined and implemented to successfully address health equity.

Medical Home Recognition Programs

In 2008, the National Committee for Quality Assurance (NCQA) first offered its Patient-Centered Medical Home (PCMH) recognition for physician practices. While NCQA is best known for developing the Healthcare Effectiveness Data and Information Set (HEDIS) and for its accreditation of health plans, it has also been creating recognition programs for physician practices. This was in response to the frustration many stakeholders expressed about the challenges of measuring quality at the physician practice level, undermining the ability to hold physicians more accountable for the quality of care they provided.

THE NINE STANDARDS IN THE NCQA PCMH RECOGNITION INCLUDE:

- Access and communication
- Patient tracking and registry functions
- Care management
- Patient self-management support
- Electronic prescribing
- Test tracking
- Referral tracking
- Performance reporting and improvement
- Advanced electronic communication

Earlier this year, after extensive stakeholder input, NCQA proposed significant changes to its PCMH recognition standards. Some of the proposed revisions included increased alignment with the expected requirements for meaningful use of certified electronic health records to qualify for Medicare and Medicaid incentive payments under the HITECH Act, more explicit organizational capacity requirements, greater emphasis on culturally and linguistically appropriate services, additional requirements for community linkages, and optional requirements for patient feedback. NCQA is currently reviewing public comments and will issue its revised standards by January 2011. The NCQA PCMH recognition program has been endorsed by key physician organizations supporting the adoption of medical homes, namely the AAP, AAFP, ACP, and AOA, as well as the National Quality Forum. The NCQA recognition program has been used in most medical home demonstration projects, many of which are sponsored by the Patient-Centered Primary Care Collaborative. However, as of July 2010, less than 4,400 physicians nationwide had achieved NCQA PCMH recognition.

Meanwhile, URAC (formerly the Utilization Review Accreditation Committee), best known for its accreditation of health care utilization review companies, has proposed its program for what it is calling "patient-centered health care homes" (PCHCHs), defined as:

> *an interdisciplinary clinician led team approach to delivering and coordinating care that puts patients, families, and caregivers at the center of decisions concerning the patient's health and wellness.*

URAC will evaluate PCHCHs using three assessments: one for primary care providers/practices, one for patients, and one for a third party (a health plan or URAC), to conduct an independent assessment of the PCHCH for the purpose of awarding incentives and other recognition.

THE URAC PROVIDER ASSESSMENT CONTAINS THE FOLLOWING THIRTEEN "CHARACTERISTICS" OR REQUIREMENTS:

- Partnership agreement
- Patient registry
- Access to services
- Individual care management
- Test and imaging results
- Preventive services
- Community services and resources
- Self-management support
- Patient web portal
- Coordination of care
- Specialist referral process
- Performance reporting
- Organizational core

URAC recently solicited public comments about each of the three assessments and anticipates that the program will be finalized by January 2011. URAC is intentionally using the term "health home" rather than "medical home" and describing its process as an "education and evaluation process" in direct contrast with NCQA's PCMH recognition program. It also is not coincidental that URAC plans to finalize its program at the same time (January 2011) that NCQA plans to finalize its revisions to its PCMH recognition program. Curiously, this would be one of URAC's first processes for physician practices, a reflection of growing interest – and competition – over the various medical home models.

Most recently, the Joint Commission, primarily known for its accreditation of hospitals, is also developing a "primary care home designation" as part of its accreditation of ambulatory health care organizations (which includes community health centers). The Joint Commission-proposed designation standards are expected to be released for "field review" (public comments) in November 2010, and finalized by March 2011.

Federal Government Support for Medical Homes

Congress first weighed in on medical homes in 2006 – and again in 2008 – by authorizing the Centers for Medicare and Medicaid Services (CMS) to spend up to $100 million to implement state-level Medicare demonstration projects for patient-centered medical homes. Over the past four years, CMS has invested significant resources planning for these demonstration projects. The demonstration projects would have used the "guided care" model, developed by the Liptz Center for Integrated Care at Johns Hopkins University School of Public Health, using a nurse to coordinate care for the most complex patients in a physician panel, with home assessments, a personalized care guide for the patient (and caregivers), proactive case management, self-management support, monitoring transitions of care, and engagement of caregivers and community support resources.

CMS decided not to use the NCQA PCMH recognition for the physician practices in the demonstration projects, and instead, developed its own certification process, with the following five domains:

- Continuity
- Clinical information systems
- Delivery system redesign
- Patient/family engagement
- Coordination

Another important feature of the proposed CMS Medicare medical home demonstration project was a three-part payment system: regular fee-for-service (or managed care) payments, an additional per beneficiary monthly care management and coordination fee (for being a medical home), and finally, additional periodic pay-for-performance payments. This three-part payment model is being widely viewed as the mechanism for paying for the additional care coordination in medical homes until there is more fundamental payment reform, and it was critical for CMS to endorse this payment model for its proposed Medicare medical home demonstration projects. However, after requesting and receiving applications from states to implement the demonstration projects beginning in 2009, CMS delayed the award of the grants, and now has placed the entire demonstration on hold.

Instead, in September 2009, the U.S. Department of Health and Human Services (HHS) announced a "multi-payer medical home demonstration project," involving Medicare, Medicaid, and private payers, and renamed the concept an "advanced primary care practice" model rather than a "medical home" model. It is curious that HHS moved away from the "medical home" terminology given that "medical home" was specifically used in the then pending – and now enacted – health care reform legislation. Applications from states to participate in these demonstration projects were due in August 2010 (California did NOT apply). CMS has further clarified that it would implement these "multi-payer advanced primary care practice demonstration projects" first, then develop an advanced primary care practice demonstration project specific to federally qualified health centers (with no additional details or timeline announced yet), and only then revisit whether to proceed with any Medicare demonstration projects.

MEDICAL HOMES IN NATIONAL HEALTH CARE REFORM IMPLEMENTATION

In the Patient Protection and Affordable Care Act (PPACA), there are several provisions that will provide additional funding and support for medical homes. The first is for $25 million to state Medicaid programs to develop models, conduct demonstration projects, and evaluate "health homes" for Medicaid enrollees with chronic conditions (beginning as early as January 2011). Health homes are defined in this section of the PPACA as:

> *a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual [Medicaid enrollee] with chronic conditions to provide health home services.*

THIS SECTION OF THE PPACA OUTLINES THE SERVICES PROVIDED BY "HEALTH HOMES" TO INCLUDE:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care, including appropriate follow-up from inpatient to other settings
- Patient and family support (including authorized representatives)
- Referral to community and social support services, if relevant
- Use of health information technology to link services, if feasible and appropriate

In addition, the PPACA authorizes funding for "community health teams" to support patient-centered medical homes. Patient-centered medical homes are defined in this section as:

> *a model of care that includes a personal physician or other primary care providers, whole person orientation, coordinated and integrated care, safe and high-quality care through evidence-informed medicine, appropriate use of HIT, continuous quality improvements, expanded access to care, and payment that recognizes added value from additional components of patient-centered care.*

Finally, the new health care reform law requires the Agency for Healthcare Research and Quality (AHRQ) to establish a Primary Care Extension Program to provide support and assistance to primary care providers, using "health extension agents" (local, community-based health workers) who, among other functions, will incorporate principles of the patient-centered medical home. One hundred and twenty million dollars is available in fiscal years 2011 and 2012 for these primary care extension centers. Ultimately, the PPACA will be providing millions of additional federal dollars to fund and support medical homes.

California Legislation on Medical Homes

In 2005, ten counties were chosen by the state to receive federal matching dollars through California's hospital financing waiver (Medicaid Section 1115 Demonstration Waiver) to develop Health Care Coverage Initiative Programs (HCCI). These programs were designed to provide county coverage for very low-income single adults without dependent children who did not qualify for Medi-Cal. Coverage did not extend to undocumented individuals and new immigrants. To participate as a HCCI, one of the program requirements included providing a designated medical home, where:

> *a single provider or facility maintains all of the individual's medical information, and assignment of eligible individuals to a primary care provider, from which the individual can access primary and preventive care.*

On November 2nd California's five-year "Bridge to Reform" Section 1115 waiver proposal was approved by the federal government for approximately $10 billion. In preparation, the Governor recently signed two bills related to the implementation of this waiver, AB 342 (Perez) and SB 208 (Steinberg). Each bill has slightly different definitions of a medical home and both pieces of legislation include a caveat that the medical home elements described may be revised to align with the implementation of and funding from the Patient Protection and Affordable Care Act. SB 208 (Steinberg) also includes pilot projects to create medical homes for children eligible for California Children's Services.

In addition, the California Academy of Family Physicians has sponsored a bill to define medical homes under California state law, one of six bills related to medical homes introduced during the 2010 legislative session.[1] AB 1542 defines a medical home as:

> *a health care delivery model in which a patient establishes an ongoing relationship with a physician or other licensed health care provider acting within the scope of his or her practice, working in a physician-directed practice team to provide comprehensive, accessible, and continuous evidence-based primary and preventative care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost-effective manner.*

1 An earlier version of the bill required medical homes in California to be recognized as PCMHs by NCQA. Another provision, now deleted, would have adopted the three-part payment model CMS was going to use for the Medicare medical home demonstration projects.

UNDER AB 1542, MEDICAL HOMES IN CALIFORNIA WOULD BE REQUIRED TO HAVE THE FOLLOWING CHARACTERISTICS:

a Individual patients have an ongoing relationship with a physician or other licensed health care provider acting within his or her scope of practice, who is trained to provide first contact and continuous and comprehensive care, or if appropriate, provide referrals to health care professionals that provide continuous and comprehensive care.

b A team of individuals at the practice level collectively take responsibility for the ongoing health care of patients. The team is responsible for providing for all of a patient's health care needs or taking responsibility for appropriately arranging health care by other qualified health care professionals, including making appropriate referrals.

c Care is coordinated and integrated across all elements of the complex health care system, including mental health and substance use disorder care, and the patient's community. Care is facilitated, if available, by registries, information technology, health information exchanges, and other means to ensure that patients receive the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

d All of the following quality and safety components:

1. The medical home advocates for its 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. Licensed health care providers in the medical practice who 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. The medical home participates 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.

e 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.

As of the date of this issue brief, neither AB 1542 nor any of the other medical home bills have been passed by the California legislature. However, they reflect the increasing interest in medical homes and how the model may influence future health care delivery design and payment. California advocates should expect similar legislation to be proposed in future sessions and become engaged in these state-level implementation steps as medical home models continue to evolve.

PATIENT AND CONSUMER PERSPECTIVES ON MEDICAL HOMES

Meanwhile, patient and consumer advocates, led by the National Partnership for Women and Families, have cautioned that current medical home models are a long way from being authentically "patient centered" and have issued principles from a patient and consumer perspective about what patient-centered medical homes should include:

- An interdisciplinary team guides care in a continuous, accessible, comprehensive, and coordinated manner.
- The patient-centered medical home takes responsibility for coordinating its patients' health care across care settings and services over time, in consultation and collaboration with the patient and family.
- The patient has ready access to care.
- The patient-centered medical home "knows" its patients and provides care that is whole-person oriented and consistent with patients' unique needs and preferences.
- Patients and clinicians are partners in making treatment decisions.
- Open communication between patients and the care team is encouraged and supported.
- Patients and their caregivers are supported in managing the patient's health.
- The patient-centered medical home fosters an environment of trust and respect.
- The patient-centered medical home provides care that is safe, timely, effective, efficient, equitable, patient centered, and family-focused.

While these principles are extremely important, unfortunately, they do not highlight the needs – or the potential – of diverse and vulnerable patients, including patients of color and low-income patients, to use medical homes to improve health care quality and advance health equity.

CONCLUSION

The model of a medical home has the promise of not only improving the quality of care for patients but could also simultaneously advance health equity for patients from communities of color and other underserved populations. By increasing access, patient centeredness, patient engagement, coordination, and follow-up, all patients – especially those who often face economic, social, cultural, and linguistic barriers to accessing quality health care – will receive better care. Just as importantly, using quality measures to compare the actual performance of health care providers based on patient outcomes will raise the standard of care for all patients. Stratifying this quality data by race, ethnicity, and language will identify any disparities and enable specific interventions and focused efforts to reduce those disparities.

Patient, consumer, and community advocates, particularly from communities of color and other underserved populations, have a vital role in continuing to shape medical home models as they are developed and implemented, and then ensure that members of our communities understand and evaluate how effective medical homes will be for increasing our quality of care and advancing health equity. While there is much work to be done, advocates can start with the following activities:

1. Continue to monitor and submit public comments on the evolving models of medical homes to ensure that they address the health equity characteristics highlighted in this issue brief.
2. Encourage and work with safety net and other providers serving communities of color and other underserved populations to participate in medical home pilot programs and demonstration projects to evaluate how they can improve quality and advance equity for our communities.
3. Educate patients and health care consumers from communities of color and other underserved populations about what medical homes are and how they can use medical homes to improve the quality of the health care they receive.

CITATIONS AND RESOURCES

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www.medicalhomeimprovement.org/

American Academy of Family Physicians
www.aafp.org/pcmh

Joint Principles for a Patient-Centered Medical Home
www.medicalhomeinfo.org/Joint%20Statement.pdf

National Committee for Quality Assurance Patient-Centered Medical Home
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Patient-Centered Primary Care Collaborative
www.pcpcc.net

URAC Patient-Centered Health Care Home
www.urac.org/publiccomment/PCHCH_PublicComment.html
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Joint Commission Primary Care Home
www.jointcommission.org/AccreditationPrograms/AmbulatoryCare/Primary+Care+Home+Initiative/

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www.healthreform.gov/newsroom/factsheet/medicalhomes.html

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California Pan-Ethnic Health Network

654 13th Street
Oakland, CA 94612
(510) 832-1160 TEL
(510) 832-1175 FAX

info@cpehn.org

www.cpehn.org

CPEHN
California Pan-Ethnic Health Network

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