

# Medical Homes 101

First championed by the American Academy of Pediatrics more than 40 years ago, the medical home is a team-based health care delivery model led by a physician that provides comprehensive, continuous, and coordinated primary and preventive medical care to patients (Patient-Centered Primary Care Collaborative 2012). Following the 2001 release of the Institute of Medicine's seminal report *Crossing the Quality Chasm*, the patient-centered medical home re-entered the "health policy lexicon" as a vital strategy to improve health care quality, control costs, and eliminate disparities (Epstein et al. 2010).

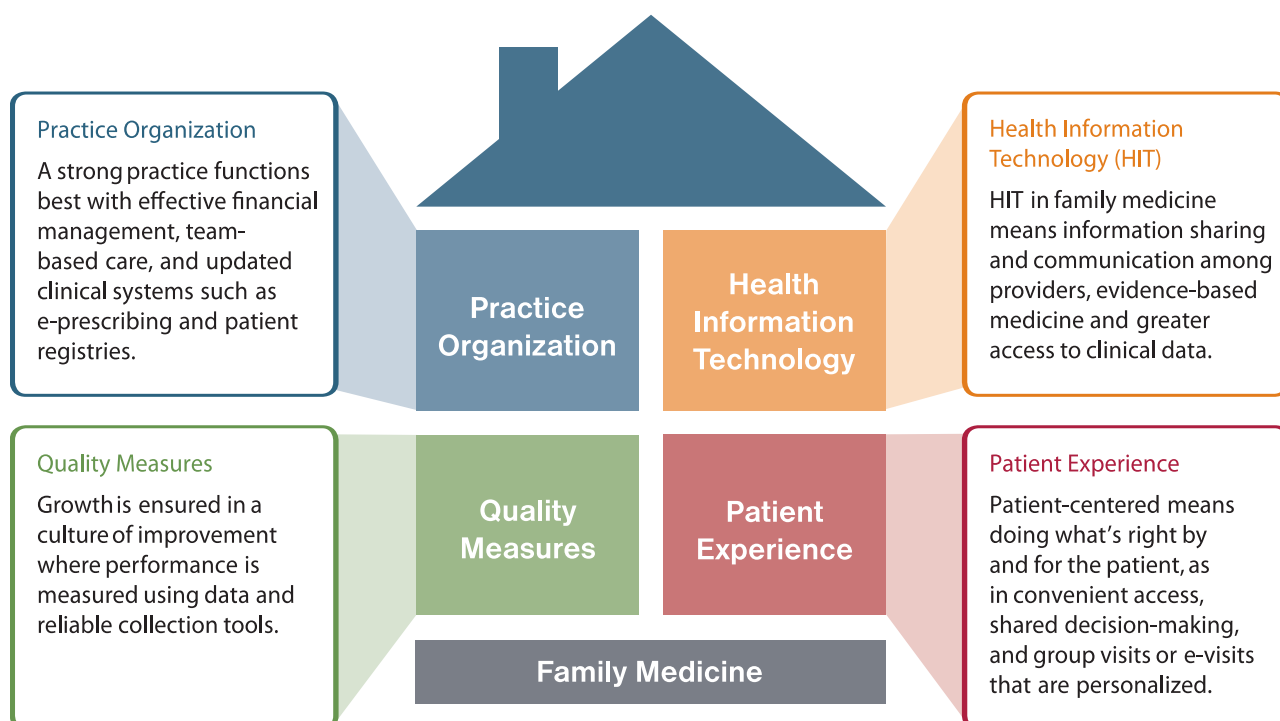
The development and expansion of the medical home (also referred to as a health home) is a centerpiece of the Affordable Care Act (ACA), and the model is quickly becoming a catalyst for multiple reform efforts related to health care delivery, reimbursement, and primary care (Nutting et al. 2011).

Access to primary care is associated with better preventive care, better management of chronic conditions, and reduced morbidity and mortality. In regions with higher ratios of primary care physicians relative to specialists, there are lower rates of hospitalizations, lower Medicare costs, and higher quality of care reported by patients (Laing et al. 2008). Over the past several decades, however, primary care has been undervalued

in favor of specialty care, due in large part to inadequate physician reimbursement, resulting in a shortage of providers and compromised access to health care, especially for low-income populations. The ACA elevates primary care through a number of provisions, among them increased support for the proliferation of medical homes (Abrams et al. 2011).

At its core, the patient-centered medical home aims to strengthen the health care system by reorganizing the way primary care practices provide care. The fundamental principles of patient-centered medical care include (Peikes et al. 2011):

- a patient-centered orientation toward each patient's unique needs, culture, values, and preferences; support of the patient's self-care efforts; involvement of the patient in care plans;
- comprehensive, team-based care that meets the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care that is delivered by a group of providers;
- care that is coordinated across all elements of the complex health care system and connects patients to both medical and social resources in the community;
- superb access to care that meets patients' needs and



Source: AAFP 2012

preferences, including care provided after hours, by e-mail, and by telephone;

- a systems-based approach to quality and safety that includes gathering and responding to patient experience data, a commitment to ongoing quality improvement, and practicing population health management (that is, reaching out to patients with chronic conditions to make sure symptoms are under control); and
- payment that recognizes the added value provided to patients who receive care in a patient-centered medical home; providers are reimbursed for time spent coordinating care and rewarded for improved patient outcomes.

### SUCCESSSES AND CHALLENGES

Creating medical homes throughout the country will require a significant restructuring of the health care delivery system. Currently, most physician practices and hospitals operate in an isolated manner—electronically and otherwise—and providing patients with around-the-clock access to coordinated care will require providers to be linked and working together (Abrams et al. 2009).

Multiple studies demonstrate how patient-centered care improves access, increases patient satisfaction, decreases mortality, prevents hospital admissions for patients with chronic diseases, lowers utilization, improves patient compliance with recommended care, and lowers health spending (Beal et al. 2007). A recent analysis of medical home pilot studies shows cost-savings through reductions in unnecessary hospitalizations and emergency department use (Abrams et al. 2011). Patients with medical homes are more likely to report better access to care, better coordination of care, improved communication with their primary care provider, and fewer medical errors (Abrams et al. 2009). Furthermore, physicians who are engaged in practices that employ a patient-centered medical home model report more joy in their work and less emotional exhaustion (Porterfield 2010). This translates into greater professional satisfaction, higher staff morale, and lower rates of turnover.

Establishing patient-centered medical homes within primary care practices is challenging, particularly within safety net systems. A survey of Federally Qualified Health Centers (FQHCs) found that health centers can provide timely access to on-site care, but many centers face barriers in providing off-site specialty care services, even for patients who have insurance (Doty et al. 2010). Forty percent of centers have electronic medical records, but their capacity for more advanced health information technology, such as electronically ordered prescriptions and tests, patient registries, and tracking patients and tests, is highly variable. The survey also found that although many FQHCs are capable of functioning as patient-centered medical homes, few report capacity in all of

NCQA's **Patient-Centered Medical Home 2011** is a set of standards that provides clear and specific criteria, and gives practices information about organizing care around patients, working in teams, and coordinating and tracking care over time. For details, go to [www.ncqa.org](http://www.ncqa.org).

the National Committee for Quality Assurance (NCQA) domains (see box).

Another challenge to the proliferation of patient-centered medical care is reimbursement. The dominant fee-for-service model, which values quantity rather than quality, fails to compensate primary health care providers for time devoted to care coordination and the provision of nonmedical services. The Center for Medicare and Medicaid Innovation, created by the ACA, is evaluating and promoting creative payment and service models, including the patient-centered medical home, as well as developing financial incentives for providers to adopt successful models (Goodson 2010).

In addition to transforming the basic mechanics of primary care practices and realigning payment structures, policymakers, payers, and providers will need to agree on the manner in which primary care practices are qualified as medical homes (for example, NCQA standards). The ACA stipulates that in order to qualify as a medical home, primary care sites will need to provide expanded access to care, comprehensive care management, coordinated and integrated care, and referral to community and social support services; have health information technology fully integrated into their practices; and conduct continuous quality improvement evaluations. A 2011 study about the transformation of 36 physician practices into medical homes showed that adopting a patient-centered approach improves the quality of care and reduces health care costs. One of the biggest hurdles, however, is time: the transition to a new model can take years (Nutting 2011).

### PHILANTHROPY AND MEDICAL HOMES

There are several ways foundations and corporate giving programs are dedicating their resources to help develop and promote patient-centered medical care.

- **The Safety Net Medical Home Initiative** – In 2008 The Commonwealth Fund, Qualis Health, and the MacColl Institute for Healthcare Innovation of the Group Health Research Institute initiated the Safety Net Medical Home Initiative (SNMHI) to help safety net primary care clinics become high-performing patient-centered medical homes. The initiative is cosponsored by The Colorado Health Foundation; Jewish Healthcare Foundation; Northwest Health Foundation; The Boston Foundation; Blue Cross

Blue Shield of Massachusetts Foundation; Partners Community Benefit Fund; Blue Cross of Idaho; and the Beth Israel Deaconess Medicaid Center.

Five regional coordinating centers were selected to participate in SNMHI, and each partnered with 12-15 safety net clinics in their respective states. All partners in the initiative are expected to participate in Medicaid and other policy reform efforts in their respective regions. The provider-community partnerships will receive technical assistance on enhanced access care coordination and improving the patient experience. They will also receive funding to support a medical home facilitator (who will lead clinic-based quality improvement projects). The work of the regional coordinating centers began in April 2009, and the initiative will continue through April 2013.

The regional coordinating centers include: The Colorado Community Health Network; The Executive Office of Health and Human Services and Massachusetts League of Community Health Centers; The Idaho Primary Care Association; The Oregon Primary Care Association and Care Oregon; and the Pittsburgh Regional Health Initiative.

SNMHI released a framework to guide primary care practices with their transformation to patient-centered medical homes. These “change concepts,” developed by SNMHI innovators and a technical expert panel comprised of providers, patients, researchers, and safety net site leaders, include:

- **empanelment** (assign patients to a provider panel);
- **continuous and team-based healing relationships** (establish and provide organizational support for care delivery teams);
- **patient-centered interactions** (respect patient/family values/needs, and expand patient role in decisionmaking);
- **engaged leadership** (visible and sustained leadership to lead overall cultural change);
- **quality improvement strategy** (establish and monitor change metrics);
- **enhanced access** (ensure all patients have continuous access to their care teams);
- **care coordination** (link patients with community resources and specialty care); and
- **use of evidence-based care** (appropriate care and case management services) (SNMHI 2008).

► **Innovation Funds** – The Community Clinics Initiative (CCI) began as a collaboration between Tides and The California Endowment in 1999 to provide resources, evidence-based programming, training, and evaluation to build the capacity of community health centers and clinics in California. In 2011, CCI/Tides and The California

Endowment developed the Health Home Innovation Fund to encourage partnerships among safety net institutions to build integrated systems of care. Seven regional efforts received \$500,000 over two years and an additional three developmental projects received \$200,000 over the same time period. Rather than propose a standard definition of “health home,” the project has elected to support the definitions and models that are emerging at the local level. Although certification may be a goal for many of the participants, the Health Home Innovation Fund is more concerned with providing flexible funding to attract local resources and with encouraging experimentation with alternative payment models that might sustain these model programs over time. Local Medicaid Managed Care Plans and County Organized Health Systems are key partners in these efforts, often contributing their own funds and in-kind staff time to support the work.

With funding from the Blue Shield of California Foundation, CCI/Tides recently announced the Community Health Center Innovation Challenge. California clinics have been encouraged to apply for grants of \$35,000 for one year to support innovative programs consistent with the Institute for Healthcare Improvement (IHI) Triple Aim objectives of improving the health of the population, enhancing the patient’s care experience, and controlling costs (IHI 2012).

As many as 22 clinics are expected to receive funding under this program, and IHI staff will help provide technical assistance in the form of webinars and in-person gatherings to strengthen the implementation of the innovations and promote the development of a statewide learning community.

## CONCLUSION

The ACA pours new resources into improving, sustaining, and expanding patient-centered medical homes within health care settings nationwide. Funders can assist with this effort by providing direct support to primary care practices to assist with their transformation to medical homes; evaluating innovative delivery and payment models; and monitoring the value these innovations bring to patients, health care quality, and expenditures.

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