Patient-Centered Medical Home
ABSTRACT: The Commonwealth Fund 2006 Health Care Quality Survey finds that adults have health insurance coverage and a medical home—defined as a health care provider, nurses, and medical homes for chronic and acute care. The survey found that rates of cholesterol, blood pressure, and prostate screening are higher among adults who receive patient reminders. When minority patients have medical homes, they are just as likely as whites to receive these services. The results suggest that all providers should take steps to create medical homes in their practices. Community health centers and other public clinics, in particular, should be supported to build medical homes for all patients.

ABSTRACT: In the United States, uninsured and low-income adults experience substantial health and health care inequities when compared with insured and higher-income individuals. A new analysis of the Commonwealth Fund 2010 Biennial Health Insurance Survey demonstrates that when low-income adults have both health insurance and a medical home, they are less likely to report cost-related access problems, more likely to be up-to-date with preventive screenings, and report greater satisfaction with the quality of their care. Moreover, the gaps in health care between them and higher-income populations are significantly reduced. The Affordable Care Act includes numerous provisions that will significantly expand health insurance coverage, especially to low-income patients, as well as provisions to promote medical homes. Along with supporting the full implementation of coverage expansions, it will be important for public and private stakeholders to create opportunities that enhance access to medical homes for vulnerable populations.
HOW MEDICAL HOMES CAN ADVANCE HEALTH EQUITY

IN SUMMARY

- Increasing evidence shows that establishing medical homes can improve health outcomes, advance health equity, and potentially reduce costs.
- Many health plans and employers, most states, and the federal government are implementing activities to establish medical homes.
- Most medical home initiatives use the National Committee for Quality Assurance (NCQA) standards for patient-centered medical homes (PCMHs).
- The NCQA is an independent, non-profit organization that manages voluntary accreditation programs for physicians, health plans, and other health care organizations.
- There are six NCQA standards for patient-centered medical homes:
  1. Enhancing access to and continuity of care.
     Especially important to social and ethnic minority populations who are the most likely to have regular sources of care.
  2. Identifying and managing patient populations.
     Viewing patients as a whole “panel” or population, primary care providers can more readily identify which patients may need more attention.

OVERVIEW

The idea of the medical home

Medical homes are trusted home bases where individuals have ongoing relationships with primary care physicians who provide and coordinate all needed care, and with whom they work together on maintaining health.

While the idea of an ongoing relationship with a physician who provides and coordinates care has existed for nearly 50 years, increasing evidence shows that establishing medical homes can improve health outcomes, advance health equity, and potentially reduce costs.

Many health plans and employers, most states, and the federal government are implementing activities to establish medical homes.

The importance of health equity

Health equity means achieving the same levels of health care quality, health care outcomes, and health status among all population groups, regardless of social and demographic characteristics such as race, ethnicity, language, gender and income.

Disparities in how health care is provided, and differences in circumstances that affect how healthy some patients are, weaken communities by unfairly burdening certain groups. In addition, when some have less access to good care, don’t have illnesses properly diagnosed, or don’t have access to treatment until they are sicker, health care costs rise for everyone.
The Role of Federally Qualified Health Centers in State-led Medical Home Collaboratives

By Mary Takach

June 2009

SAFETY NET MEDICAL HOME INITIATIVE

About the Initiative Change Concepts

Patient-Centered Care for the Safety Net

The Safety Net Medical Home Initiative is a national Patient-Centered Medical Home demonstration that is helping 65 primary care safety net sites become high-performing medical homes and improve quality, efficiency and patient experience. Learn more about the Initiative.

The Initiative created a framework for PCMH transformation and has published a library of resources and tools to help practices implement the PCMH Model of Care. Access our PCMH materials.
Becoming a Patient-Centered Medical Home

Source: Centers for Medicare & Medicaid Services

There are 500 FQHCs participating in this demonstration.
Safety Net Hospitals Establish “Medical Homes”

What is a “Medical Home?”

The term “medical home” was first used by the American Academy of Pediatrics in the 1967 publication Standards of Child Health Care to describe a “central source of a child’s pediatric record.” This phrase has since evolved to describe a health care delivery site where patients have a continuous relationship with a personal physician who provides patient-centered, coordinated, and high-quality care with adequate reimbursement mechanisms to cover all provided services. The National Committee for Quality Assurance (NCQA), which accredits medical homes, defines the term as “a model for care... that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship.”

Current health reform efforts endeavor to restructure a highly fragmented health care system by increasing integration, coordination, and access to care. The medical home model and the related notion of integrated delivery systems (IDS) are gaining traction in Washington, DC, as strategies to improve health care in the U.S. If IDS is defined as “a coordinated continuum of services [that] is held clinically and fiscally accountable for the health status of the population served,” the medical home is the primary care component of such a continuum.

NAPH Reviews Medical Homes at Safety Net Hospitals

Many hospitals, including members of NAPH, have implemented the medical home care model within their affiliated clinics. NAPH researchers conducted a study of medical homes at safety net hospitals and health systems and found 46 such programs at 37 member facilities. They conducted telephone and email interviews with staff at 23 sites and analyzed the programs to identify common themes. This Research Brief reports on these findings, explores current trends in medical home implementation at member hospitals, and considers potential policy implications for medical homes in the future.

REASONS FOR MEDICAL HOME ADOPTION

NAPH conducted interviews with CEOs, medical directors, and/or program directors at 23 of the 46 medical...
Press Release

FOR IMMEDIATE RELEASE
March 31, 2011

NYC Public Hospitals and Health Centers Receive Patient-Centered Medical Home Designation

New York, NY - The New York City Health and Hospitals Corporation (HHC) today announced that all of its 11 hospitals and six large community health centers have received medical home designation for delivering accessible, comprehensive and family-centered primary care to New Yorkers that aims to reduce avoidable healthcare costs over time. The special designation was granted by the National Committee for Quality Assurance (NCQA) to 616 primary care physicians who collectively care for nearly 100 percent of HHC's primary care population of more than 477,000 adult and pediatric patients. All of the HHC facilities received "Level 3" designation, the highest ranking, which will qualify HHC for more than $15 million in Medicaid reimbursement rate increases every year.
CALIFORNIA BRIDGE TO REFORM A SECTION 1115 WAIVER

March 2010

POLICY BRIEF

Medical Homes in the Safety Net: Spotlight on California’s Public Hospital Systems
**National Ambulatory Medical Care Survey**

Table 2. Office visits, by selected physician practice characteristics: United States, 2010

<table>
<thead>
<tr>
<th>Physician practice characteristics</th>
<th>Number of visits in thousands (standard error in thousands)</th>
<th>Percent distribution (standard error of percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All visits</td>
<td>1,008,802 (46,471)</td>
<td>100.0 (---)</td>
</tr>
<tr>
<td><strong>Ownership</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician or group</td>
<td>810,758 (45,777)</td>
<td>80.4 (2.0)</td>
</tr>
<tr>
<td>Other health care corporation</td>
<td>88,791 (14,413)</td>
<td>8.8 (1.4)</td>
</tr>
<tr>
<td>Other hospital</td>
<td>33,552 (9,631)</td>
<td>3.3 (0.9)</td>
</tr>
<tr>
<td>HMO¹</td>
<td>23,828 (4,588)</td>
<td>2.4 (0.5)</td>
</tr>
<tr>
<td>Community health center</td>
<td>20,256 (3,080)</td>
<td>2.0 (0.3)</td>
</tr>
<tr>
<td>Medical or academic health center</td>
<td>18,110 (5,135)</td>
<td>1.9 (0.5)</td>
</tr>
<tr>
<td>Other²</td>
<td>*10,766 (3,438)</td>
<td>*1.1 (0.3)</td>
</tr>
<tr>
<td>Blank</td>
<td>*1,742 (1,141)</td>
<td>*0.2 (0.1)</td>
</tr>
<tr>
<td><strong>Practice size</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solo</td>
<td>317,427 (24,662)</td>
<td>31.5 (1.9)</td>
</tr>
<tr>
<td>2</td>
<td>116,311 (14,491)</td>
<td>11.5 (1.3)</td>
</tr>
<tr>
<td>3-5</td>
<td>247,820 (23,329)</td>
<td>24.6 (1.8)</td>
</tr>
<tr>
<td>6-10</td>
<td>180,579 (15,890)</td>
<td>17.9 (1.6)</td>
</tr>
<tr>
<td>11 or more</td>
<td>142,306 (17,312)</td>
<td>14.1 (1.6)</td>
</tr>
<tr>
<td>Blank</td>
<td>*4,360 (2,704)</td>
<td>*0.4 (0.3)</td>
</tr>
</tbody>
</table>

*Note: Percentages may not sum to 100 due to rounding.*
Visits to Primary Care Delivery Sites: United States, 2008

Esther Hing, M.P.H., and Sayeedha Uddin, M.D., M.P.H.

Key findings
- In 2008, the majority of visits to primary care delivery sites (84%) occurred in physician offices, 11% in hospital outpatient departments (OPDs), and 5% in community health centers (CHCs).

Figure 1. Percent distribution of visits to primary care sites, by setting and poverty level in patient’s ZIP Code: United States, 2008

- Blue: Physician offices
- Light Blue: Community health centers
- Green: Outpatient departments
Quality Improvement in Solo and Small Group Practice

Strengthening the Private Practice Safety-Net

Report Prepared By:

Elissa Maas, MPH
Vice President, CMA Foundation

Lisel Blash, Scientist
Public Research Institute
San Francisco State University

Carol Lee, Esq.
President & CEO, CMA Foundation

December 2008

ASIAN AMERICAN PHYSICIANS IN SOLO AND SMALL GROUP PRIMARY CARE PRACTICES:

ESSENTIAL HEALTH CARE PROVIDERS FOR OUR COMMUNITIES

November 2012

By

Ignatius Bau and Ho Luong Tran, MD, MPH

with assistance from

Barbara Cardinal, David Hawks, Kim Tran, and Grace Yoo, PhD
While the majority of practice improvement efforts in the U.S. have supported community health centers and larger practice settings, there is increasing investment by federal and state government, philanthropies, professional societies, and non-profit organizations in quality improvement and redesign for small practices. This shift is not surprising. The challenges of engaging providers who are generally less equipped with the technology and infrastructure needed for effective chronic care are real, as are the difficulties of developing a scalable and sustainable practice improvement model to address their needs. Small practices likely will face greater hurdles to use of important but complex frameworks of care such as the patient-centered medical home (PCMH) and Chronic Care Model.

Approximately 60 percent of physicians work in practice settings with only one to four providers. Yet small practices are apt to remain an important piece of the current health care delivery system for years to come, playing a substantial role in caring for low-income and racially and ethnically diverse Medicaid beneficiaries. Unfortunately, these practices include physicians who are likely to retire before they adapt to a new primary care environment. They are also often under-resourced, disenfranchised from the larger health care system, and isolated from other providers and quality improvement initiatives. In the absence of external support, small practices risk falling further behind in chronic care management, health information technology (HIT), and quality of care, compared to their larger, more integrated peers.
Six Standards for NCQA
Patient-Centered Medical Home (PCMH)

1. Enhance Access & Continuity
2. Identify & Manage Patient Populations
3. Plan & Manage Care
4. Provide Self-Care & Community Support
5. Track & Coordinate Care
6. Measure & Improve Performance
1. Enhance Access & Continuity

- PCMH Element 1F: Culturally and linguistically appropriate services
- Factor 1F1: Assess the racial and ethnic diversity of its population
- Factor 1F2: Assess the language needs of its population
- Factor 1F3: Provides interpretation or bilingual services to meet the language needs of its population
- Factor 1F4: Provides printed materials in the languages of its population
1. Enhance Access & Continuity

- PCMH Element 1G: The practice team
- Factor 1G5: Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change
- Factor 1G6: Training and assigning care teams for patient population management
- Factor 1G7: Training and designating care team members in communication skills
1. Enhance Access & Continuity

- Explain medical home
- Empanel/assign provider and care team
- Provide expanded access, same-day appointments, afterhours access
- Facilitate communication with entire care team
- Provide electronic access for appointments, refills, test results
- Explain medical home in culturally and linguistically appropriate way
- Match patient with culturally and linguistically concordant provider and care team
- Hire care team members that reflect patient population
- Ensure language access
2. Identity & Manage Patient Populations

- PCMH Element 2A: Use an electronic system that records the following as structured (searchable) data for more than 50% of its patients:
  - Factor 2A3: Race
  - Factor 2A4: Ethnicity
  - Factor 2A5: Preferred language

- PCMH Element 2C: Comprehensive health assessment includes:
  - Factor 2C2: Family/ social/ cultural characteristics
  - Factor 2C3: Communication needs
2. Identity & Manage Patient Populations

- Document demographic and clinical data electronically
- Use clinical decision support to provide evidence-based care
- Use standing orders and electronic prescribing
- Identify high risk and high need patients that need more support (registries)
- Document granular demographic information (race, ethnicity, language)
- Be knowledgeable about health disparities and additional screenings relevant to one’s patients
- Identify cultural, linguistic, and literacy barriers to care for high risk and high need patients
3. Plan & Manage Care

- Develop individual care plan, with individual goals
- Engage patient, family, caregivers in care plan
- Support shared decisionmaking about care
- Send reminders to patients and use provider alerts
- Identify and respond to needs of high-risk, complex patients
- Ensure culturally and linguistically appropriate care plan
- Identify and address barriers to care for vulnerable populations, including health literacy
- Engage and provide culturally and linguistically appropriate tools to patient, families, and caregivers
4. Provide Self-Care & Community Support

- PCMH Element 4A: Support self-care process
  - Factor 4A1: Provides educational resources or refers at least 50% of patients/families to educational resources to assist in self-management
  - Factor 4A2: Uses an EHR to identify patient-specific education resources and provide them to >10% patients, if appropriate

- PCMH Element 4B: Provides referrals to community resources
  - Factor 4B1: Maintains a current resource list on five topics or key community service areas of importance to the patient population
4. Provide Self-Care & Community Support

- Support patient education
- Support patient self-management
- Share summaries of care
- Provide access to health information
- Engage families and caregivers
- Provide referrals to community resources
- Ensure patient education is culturally and linguistically appropriate
- Address health literacy in patient education and tools
- Provide access to health information in multiple languages, channels, formats
- Include community resources focused on diverse communities and health disparities
5. Track & Coordinate Care

- Proactively track tests and referrals
- Follow-up directly with patients when tests or referrals not completed
- Coordinate care with labs, specialists, hospitals, and other providers
- Ensure coordinated transitions of care
- Conduct medication reconciliations
- Ensure culturally and linguistically appropriate referrals
- Identify and address barriers for vulnerable populations, including health literacy and finances
- Engage patients, families, and caregivers in care coordination
- Share care coordination documents with patients
6. Measure & Improve Performance

- PCMH Element 6A: Measure performance
- Factor 6A4: Performance data stratified for vulnerable populations (to assess disparities in care)
- PCMH Element 6B: Patient/family feedback
- Factor 6B3: The practice obtains feedback in the experiences of vulnerable populations
- Factor 6B4: The practice obtains feedback from patients/families through qualitative means
6. Measure & Improve Performance

- PCMH Element 6C: Implement continuous quality improvement
- Factor 6C3: Set goals and address at least one identified disparity in care or service for vulnerable populations
- Factor 6C4: Involve patients/families in quality improvement teams or on the practice’s advisory council
6. Measure & Improve Performance

- Identify and act on opportunities to improve quality
- Measure and improve patient experience of care
- Publicly report quality measures
- Seek continuous quality improvement
- Stratify all quality data by race, ethnicity, and language
- Identify and reduce disparities
- Oversample vulnerable patients for feedback on experience of care
- Improve patient experience of care for vulnerable patients
- Engage diverse patients in quality improvement efforts
### Health Care Home Payment Methodology: Structure and Design

#### HCPCS Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>S0280</td>
<td>medical home program, comprehensive care coordination and planning, initial plan</td>
</tr>
<tr>
<td>S0281</td>
<td>medical home program, comprehensive care coordination and planning, maintenance</td>
</tr>
</tbody>
</table>

#### Modifiers

<table>
<thead>
<tr>
<th>Tier</th>
<th>Patient Complexity Level</th>
<th>Primary Language Non-English</th>
<th>Severe and Persistent Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Low</td>
<td>(no modifier)</td>
<td>U3</td>
</tr>
<tr>
<td>1</td>
<td>Basic</td>
<td>U1</td>
<td>U3</td>
</tr>
<tr>
<td>2</td>
<td>Intermediate</td>
<td>TF</td>
<td>U3</td>
</tr>
<tr>
<td>3</td>
<td>Extended</td>
<td>U2</td>
<td>U3</td>
</tr>
<tr>
<td>4</td>
<td>Complex</td>
<td>TG</td>
<td>U3</td>
</tr>
</tbody>
</table>

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Minnesota Department of Human Services
Minnesota Department of Health

January 2010
Decrease racial and ethnic disparities:
Participate in initiatives to decrease racial and ethnic health disparities, including but not limited to: participating in educational forums; collecting and analyzing data to review disparities related to race and ethnicity; and engaging in efforts to act on data-driven opportunities for improvement that reduce disparities.
REDUCING RACIAL AND ETHNIC DISPARITIES THROUGH CONNECTICUT'S PERSON-CENTERED MEDICAL HOMES A TOOLKIT FOR PROVIDERS

Prepared by Meryl F. Price and Ignatius Bau For the Connecticut Department of Social Services Funded by the Connecticut Health Foundation March 2013
With Healthy Way L.A., you choose a permanent medical home at one of more than 100 clinic sites. With a medical home, you go to the same location for nearly all of your medical care needs. Your medical home is staffed by providers who know you by name and how to keep you in optimal health.
Recommendations

- Educate and engage diverse and vulnerable patients, families, caregivers about medical homes
- Sponsors/payers for medical home initiatives can highlight opportunities for disparities reduction/health equity, including additional requirements and payments
- Monitor NCQA PCMH standards specific to health equity for compliance and improvement
- Develop and disseminate technical assistance to medical home practices on achieving health equity
PATIENT-CENTERED MEDICAL HOMES AND HEALTH EQUITY

http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home


http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/May/1600_Berenson_achieving_better_quality_care_low_income_v2.pdf

http://www.cpehn.org/pdfs/Medical%20Homes.pdf

Bau I. Advancing Health Equity through Medical Homes, Connecticut Health Foundation (2012)  


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http://www.safetynetmedicalhome.org/

Center for Medicare and Medicaid Services, Federally Qualified Health Center Advanced Primary Care Practice Demonstration  

http://www.naph.org/Main-Menu-Category/Publications/Quality/Medical-Homes-Brief.aspx

New York City Health and Hospitals Corporation  

http://www.caph.org/content/upload/AssetMgmt/PDFs/Publications/MedicalHomePolicyBriefMarch2010.pdf

National Center for Health Statistics, National Ambulatory Medical Care Survey 2010 Summary Data  
Hing E, Uddin S. *Visits to Primary Care Delivery Sites – United States, 2008*. National Center for Health Statistics Data Brief No. 46 (2010)  
http://www.cdc.gov/nchs/data/databriefs/db47.pdf


http://www.health.state.mn.us/healthreform/homes/payment/PaymentMethodology_March2010.pdf


Healthy San Francisco  
http://www.healthysanfrancisco.org/participants/accessing_services/your_medical_home.aspx

Healthy Way L.A.  
http://www.ladhs.org/wps/portal/HWLA

**OTHER REFERENCES AND RESOURCES**

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http://preventioninstitute.org/component/jlibrary/article/id-298/127.html


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Anderson DR, Olayiwola JN. Community health centers and the patient-centered medical home: Challenges and opportunities to reduce health care disparities in America. *J Health Care Poor Underserved.* (2012);23(3): 949-957


Safety Net Medical Home Scale

http://www.aapcho.org/resources_db/the-role-of-enabling-services-in-patient-centered-medical-homes/

Clarke RMA, Tseng C, Brook RH, Brown AF. Tool used to assess how well community health centers function as medical homes may be flawed. *Health Aff.* (2012); 31(3):Webfirst 1-9

Lewis SE, Nocon RS, Tang H, Park SY, Vable AM, Casalino LP, Huang ES, Quinn MT, Burnet DL, Summerfelt WT, Bimberg JM, Chin MH. Patient-centered medical home characteristics and staff morale in safety net clinics. *Arch Intern Med.* (2012);172(1):23-31

