Medical and Health Homes: An Overview

There are many definitions and descriptions of "medical homes." The concept began in the context of maternal and child health. **The American Academy of Pediatrics (AAP**) initiated the concept in 1967, referring to a medical home as a "central location for archiving a child's medical record." In a policy statement issued in 2002, it expanded the concept to include the following operational characteristics: "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care."

The National Committee for Quality Assurance (NCQA), the best known of the organizations that certify entities as patient-centered medical homes,[1] describes a PCMH as follows:

> "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. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner."[2]

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have developed their own models for improving patient care called the "medical home" (2004) or "advanced medical home" (2006). These three entities plus the American Osteopathic Association (AOC), which together represent about 333,000 physicians, use the same description as NCQA, and identify the following principles as necessary to a PCMH (the whole person orientation and coordinated care principles seem particularly relevant for HIV-centered care):

> ***"Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
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> ***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
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> ***Whole person orientation*** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
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> ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated

[1] The other certifying entities are the Joint Center (formerly the Joint Center for the Accreditation of Healthcare Organizations or JCAHO), the Accreditation Association for Ambulatory Health Care (which accredits some 5,000 organizations in a wide variety of ambulatory health care settings), and URAC (which once focused primarily on uniform standards for utilization review but now works more broadly on health care quality).

[2] See NCQA, "Patient-Centered Medical Home" at http://www.ncqa.org/tabid/631/default.aspx

> care when and where they need and want it in a culturally and linguistically appropriate manner.
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> ***Quality and safety*** are hallmarks of the medical home….
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> ***Enhanced access*** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
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> ***Payment*** appropriately recognizes the added value provided to patients who have a patient-centered medical home…."[3]

Until the last several years, most of the entities obtaining certification as PCMHs have been private physician practices, although a number of community health centers and other safety-net clinics are now obtaining such certification.

The State of Maryland has a legislatively authorized PCMH program. It describes medical homes in the following terms:

> "The PCMH is a model of practice in which a team of health professionals, guided by a primary care provider, provides continuous, comprehensive, and coordinated care in a culturally and linguistically sensitive manner to patients throughout their lives. The PCMH provides for all of a patient's health care needs, or collaborates with other qualified professionals to meet those needs. Participating practices will provide patient centered care through:
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> - evidence-based medicine;
> - expanded access and communication;
> - care coordination and integration; and,
> - care quality and safety."[4]

Maryland's is one of a growing number of state PCMH programs. It requires participation by the largest insurance companies operating in the state, and helps selected multi-payer providers (those that receive third party reimbursements from multiple sources) to achieve PCMH status through NCQA certification. Participating primary care providers can be physician-owned, hospital-owned, part of a faculty practice organization, or Community Health Centers/Federally Qualified Health Centers (CHCs/FQHCs).

The Patient Protection and Affordable Care Act (health care reform legislation) encourages the use of "health homes" or medical homes. There are several legislative references; particularly relevant to HIV-centered care is the following:

> **Title II Subtitle I**
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> **Sec. 2303 – Payment. See Amendment by Reconciliation Act below**

[3] See "Joint Principles of the Patient-Centered Medical Home," at http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home

[4] See Maryland's Patient Centered Medical Home Program, at http://mhcc.maryland.gov/pcmh/

> **Sec. 2703. State option to provide health homes for enrollees with chronic conditions.** Provide States the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination."[5]

The Center for Medicare and Medicaid Services (CMS) is encouraging the development of health homes for people with chronic illness. In its November 16, 2010 letter on "Health Homes for Enrollees with Chronic Conditions", CMS references Section 2703 of the Affordable Care Act, entitled "State Option to Provide Health Homes for Enrollees with Chronic Conditions." The CMS letter says:

> The health home service delivery model is an important option for providing a cost-effective, longitudinal "home" to facilitate access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions.
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> Health homes can play a particularly pivotal role in improving the health care delivery system for individuals with chronic conditions. Consistent with the intent of the statute, we expect States that provide this optional benefit, and the health home providers with which the State collaborates, to operate under a "whole-person" philosophy – caring not just for an individual's physical condition, but providing linkages to long-term community care services and supports, social services, and family services. The integration of primary care and behavioral health services is critical to the achievement of enhanced outcomes.[6]

Some states, including New York, are developing these health homes. New York specifically includes HIV as a chronic illness in its health home planning; the state has a special demonstration grant from CMS. New York's Part A program is establishing HIV-focused health homes as part of its preparation for implementation of health care reform. It is also establishing primary care/behavioral health medical homes.

Safety Net Providers and PCMH: A growing number of safety net providers have become certified as PCMHs or working on such recognition. Included are community health centers, Federally Qualified Health Centers (FQHCs), and other safety net clinics, and some HIV-focused providers. For example:

- A number of DC-area clinics have received funding from area health care foundations to pursue or enhance medical home status. Among them are FQHCs and look-alikes such as Family Medical and Counseling Service, a long-time HIV/AIDS provider and newly FQHC; Whitman Walker Health, an FQHC look-alike; and other FQHCs such as Mary's Center for Maternal and Child Care, Unity Health Care, and Greater Baden Medical Services, Inc. (part of a collaborative with the Community Clinic, Inc.). Among the non-FQHCs are Arlington

[5] "Health Care Reform and the Patient-Centered Medical Home." See http://www.pcpcc.net/content/health-care-reform-and-patient-centered-medical-home.
[6] See http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

Pediatric Center, Arlington Free Clinic, the Spanish Catholic Center, and the Primary Care Coalition of Montgomery County (working with two hospital-based clinics).

- The Safety Net Medical Home Initiative is helping safety net clinics, primarily CHCs/FQHCs, to become PCMHs. Its purpose is to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative is funded by a group of funders led by the Commonwealth Fund, administered by Qualis Health, and run in partnership with the MacColl Institute for Healthcare Innovation at the Group Health Research Institute. Five regions were selected competitively for participation. Most of the groups are primary care associations; they are located in Colorado, Idaho, Massachusetts, Oregon, and Pittsburgh. Together, they include 65 safety net clinics. The initiative is generating some useful research as well as tools that other clinics can use as they pursue PCMH status.[7]
- A number of HIV/AIDS service providers throughout the country have received or are pursuing medical homes, and the DC Department of Health is exploring medical homes as an HIV/AIDS service model.
  - The Inova Juniper Program, which provides HIV/AIDS care in Northern Virginia as part of the non-profit Inova Health System, recently received recognition as a Level 3 patient-centered medical home.
  - The Metropolitan Hospital Center in New York City, a "designated AIDS Center, has PCMH status, and says that "The medical home designation recognizes Metropolitan's model of care, where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for comprehensive care of the patient. As a medical home, we ensure that coordinated care and long term healing replace episodic care based on illness."[8]
  - AIDS Care in Rochester received Patient-Centered Medical Home Designation by the National Committee for Quality Assurance (NCQA) in January 2012 "for its delivery of accessible, comprehensive and family-centered primary care to the Greater Rochester and Finger Lakes Areas. The organization and its four medical providers, who collectively care for approximately 700 patients at AIDS Care, received Level 3 designation (the highest ranking) which will qualify AIDS Care for Medicaid reimbursement incentives every year."[9] According to the organization, "While the medical provider will lead the care team, the focus is on care coordination and a multidisciplinary approach. The patient has access to a care manager to help them navigate the system, as well as the full range of supportive services, such as: behavioral wellness, education, nutrition counseling, and treatment adherence, to help meet their needs." The organization sees this status as a foundation for its work under health care reform.
  - During a January 2011 technical assistance conference call on the National HIV/AIDS Strategy, held jointly by the **Bureau of Primary Health Care and the Health Resources and Services Administration (HRSA)**, the desired link between Ryan White and CHCs/FQHCs was emphasized in the context of medical homes:

[7] See www.qhmedicalhome.org/safety-net
[8] See http://www.nyc.gov/html/hhc/mhc/html/services/hiv.shtml
[9] See http://www.acrochester.org/en/news/30/aids-care-receives-level-3-patient-centered-medical-home-designation

> "[Community] Health Centers are already moving toward becoming patient-centered medical homes, a model that puts the patient at the center of the health care system through more coordinated care. Part of the medical home model depends on the right staff, the right mix of staff, and the correct delivery of care so clinics know they are doing the right thing for patients. HIV/AIDS care as provided by Ryan White programs reflects the medical home model and can prove instructive to Health Centers."[10]

The number of safety net clinics seeking and obtaining medical home status is likely to continue growing. Whether the DC region will obtain CMS funding to establish chronic care health homes is uncertain.

[10] "National HIV/AIDS Strategy: Improving HIV/AIDS Care in the Health Center Community," Summary of a HRSA/BPHC Grantee TA Call, January 31, 2011. See http://bphc.hrsa.gov/technicalassistance/taresources/nhascallnotes040111.pdf.pdf