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## What Are The Accommodations In A “Medical Home?”

*by Melissa Jones, Esq., Health Policy Analyst*

There has been much debate nationally about what should constitute a “medical home,” the notion that a central person should be designated to provide preventive care and coordinate with others about a patient’s needs.

Though the term was coined decades ago as a method of coordinating child medical care through a primary-care physician, that medical-home model has been criticized as having too narrow a focus on medical needs and not on other services offered by non-medical providers such as nutritionists, behavioral health services providers and substance-abuse counselors.

The California Center for Rural Policy embraces the widest possible definition of medical home. This is particularly critical in rural areas such as the Redwood Coast Region of California, where people are on average older, poorer, have higher rates of chronic disease—and are more likely to be medically uninsured.

What’s more, such rural areas are experiencing physician shortages and rely more on nurse practitioners and physician assistants as primary care providers working in a team environment under the supervision of a physician.

The term medical home is defined broadly in the federal health care reform bill, The Patient Protection and Affordable Care Act; but the definition of medical home varies from state to state. In California, two bills with narrow

definitions are moving through the California legislature: AB 1542(Jones) and SB 966(Alquist). California is also due to renew its Section 1115 Medicaid waiver this year, and a broad definition of medical home has been included in the final waiver concept paper.<sup>1</sup>

Three models will be covered in this report. The first model is the founding one, patient-centered medical home. The second model, health home, broadens and expands medical home. The third model is called a person-centered healthcare home, and specifically recognizes behavioral health needs.

### Definitions of Terms

**Patient-Centered Medical Home:**

The originating term describing a comprehensive team approach to coordinating patient care between the patient, providers, and family.

**Health Home:** Alternative term to address a broader team based approach that includes social and community services providers.

**Person-Centered Healthcare Home:** Proposed by the behavioral health community to emphasize the need for mental and behavioral health providers in a medical home model.

## Patient-Centered Medical Home

Patient-centered medical home (PCMH) is a term that was created by the American Academy of Pediatrics in 1967, to refer to the physical location of a child's medical record with a primary physician who would coordinate care with specialists and communicate with family members.<sup>4,5</sup>

In 2007, the American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians and American Osteopathic Association developed the "Joint Principles of the Patient-Centered Medical Home" and defined the PCMH as, "an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family."<sup>6</sup>

A primary care physician coordinates services with other providers such as specialists, hospitals, and/or nursing homes. Recently, additional elements have been added to the PCMH model such as the use of evidence based decision making, health information technology and use of electronic medical records to facilitate coordination of care between various providers.<sup>5</sup>

The PCMH model has been criticized because of the focus on medical needs and the fear that insurance companies will not cover other services offered by non-medical providers, even if necessary for a particular patient's medical home. Additionally, some advocates are worried that the central provider of a medical home will only be defined as a physician, when nurse practitioners (NPs) and physician assistants (PAs) can often successfully fulfill this role.

## Health Home

The California Endowment (TCE) embraces the health home model in their "building healthy communities" initiative. TCE's health home definition "involves primary care practitioners partnering with the patient and family to provide accessible, comprehensive, family-centered, culturally competent, and prevention oriented care."<sup>5</sup> The health home specifically identifies the broad range of professionals and community services that contribute

to an individual's care including: legal aid, oral health, social work, pharmacy services, behavioral and mental health.<sup>5</sup>

The health home is a combination of a medical home and the chronic care model.<sup>5</sup> The chronic care model was created to decrease isolated treatment of acute episodes in patients with multiple chronic illnesses.

Other organizations, such as the American Public Health Association support a broad definition of health home that includes preventive and social or community services.<sup>7</sup> The health home model is also used in federal legislation (please see the "Federal Level" section of this report).

## Person-Centered Healthcare Home

Many advocates claim that a primary care provider may not be the best coordinator of care for individuals with serious behavioral health needs<sup>9</sup> because they might receive care through a mental health provider. Additionally, the needs of this population are generally greater than that of a typical person and those with serious mental illnesses have higher rates of illness and death so effectively addressing their needs in a medical home cannot be ignored.<sup>8</sup>

The person-centered healthcare home is an emerging term offered by the National Council for Community Behavioral Healthcare (NCCBH) to address this. The NCCBH stresses the importance of including behavioral health services<sup>9</sup> in a home model of care. In essence, it combines primary care coordination with behavioral health care. The mental health community hopes to shift the emphasis from medical terminology (medical home, patient-centered care) to more inclusively incorporate mental health, substance abuse and co-occurring disorders; perhaps even with a mental health setting serving as a health care home for some individuals.<sup>10</sup>

This concept is widely supported by local and statewide entities. Humboldt County Health and Human Services supports the concept, and statewide organizations such as the California Mental Health Directors Association, California Council of Community Mental Health Agencies, California Institute for Mental Health, County Alcohol and Drug Program Administrators Association of California,

California Alliance of Child and Family Services, and Alcohol and Drug Policy Institute also strongly advocate for it. Additionally, person-centered healthcare home has been included in the state's section 1115 waiver implementation plan.<sup>11</sup>

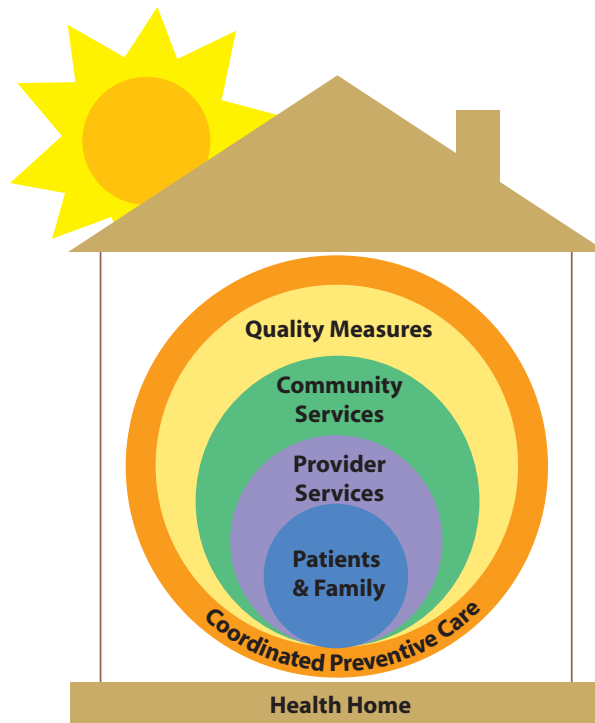
### Medical Homes in Legislation

As mentioned previously, the medical home model has been included in recent legislation, both federally and within California. The Patient Protection and Affordable Care Act (hereinafter reform bill) includes both medical home and health home as a way for states to receive additional federal funds for programs embracing these models. Any state legislation should adopt a broad definition of medical home to take advantage of any opportunities to receive additional federal funding. If medical home is to become the prevalent model then all terms or models used should be consistent with one another.

#### Federal Level

The reform bill allows states to amend their Medicaid plan to provide health homes<sup>12</sup> for chronically ill patients. The bill defines health home broadly but lists specific services to be included in a health home: “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, and, use of health information technology to link services, as feasible and appropriate.”<sup>13</sup>

Additionally, the reform bill indicates that these services can be administered by a provider in coordination with a “team of health professionals.” The definition of this team allows the state to



describe the term but gives guidelines that specifically mention providers from many different disciplines such as behavioral health, nutritionists, care coordinators, and social workers.<sup>13</sup>

The reform bill also establishes a pilot program that will be available to states and Native American tribes. The pilot focuses on the creation of interdisciplinary, interprofessional teams to support “patient-centered medical homes.” Again, it allows the grantee to define the health team which will provide care, but outlines

what professions the team may include.

This provision includes several different disciplines: “medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians’ assistants.”<sup>13</sup>

The federal reform bill will increase access to health care for many currently uninsured Americans. This will further strain already overworked primary care physicians. In order to help alleviate the primary care physician shortage, it will be important to recognize NPs and PAs as primary care providers.

#### State Level

California currently has two bills in the legislature that mention patient-centered medical home. Neither bill defines medical home as broadly as the federal definitions. AB 1542(Jones) provides for a patient-centered medical home pilot project. SB 966(Alquist) instructs the Department of Health Care Services to define medical home and provides a timetable for Medi-Cal managed care plans to provide patients with a medical home.<sup>14</sup>

Both bills use the term medical home as defined by the National Committee for Quality Assurance (NCQA).<sup>15,16</sup> The NCQA is an accreditation body that groups and rates medical home practices. The definition specifically provides that the medical home will center on a personal physician, no other provider.

Regarding coordination of care, the definition requires that the personal physician coordinate across “all elements of the complex health care system and the patients community” but does not recognize the critical role that other providers such as mental health and substance abuse workers or care managers may play. The definition only provides that a medical home will, when appropriate, utilize partnerships for non-medical services needed by the patient.<sup>15,16</sup> Interestingly, the NCQA definition does not exactly match the joint principles established by the four organizations described above. This inconsistency may be problematic in the future.

Furthermore, NPs and PAs, who are essential players in rural communities, are not specifically mentioned. NPs are playing an increasingly important role in providing primary care to patients, especially in areas where physician shortages exist. Unlike physicians, nearly half of the NP workforce chooses to go into primary care instead of seeking out specialty care.<sup>17</sup>

Studies have found that NPs provide the same quality of care and have similar patient outcomes to physicians.<sup>18,19</sup> Fewer studies have been done on the quality of care results from PA practice.<sup>20</sup> However, the studies that have been done suggest that care provided by a PA is comparable to physician care.<sup>20,21</sup>

Expanding the medical home definition to include NPs and PAs will increase access to preventive care for everyone.

### **Medicaid Waiver**

The Legislature required the state of California to apply to renew its 1115 Medicaid waiver this year in accordance with certain goals outlined in ABx4 6.<sup>22</sup> The Medicaid waiver application seeks to build on existing Medicaid managed care models and employ medical homes to coordinate care for a number of high-cost target populations. One medical home model will include the possibility that beneficiaries with serious

mental illness and/or substance use disorders could use their mental health treatment settings as their person-centered healthcare home.<sup>11</sup>

### **Conclusion**

CCRP supports the use of a more generic term, such as health home, that addresses the needs of all interests (chronically ill, mentally ill, special needs, behaviorally challenged, etc).

Regardless of the semantics, the concept of a medical or health home is critical to improving health in our communities and should be actively pursued by policy-makers and health and human service providers. It will be important to coordinate with all jurisdictions and interests.

CCRP also supports the inclusion of nurse practitioners and physician assistants as medical home providers. Ensuring the health of rural people will depend on everyone in our community having adequate access to their primary care provider, especially once federal health care reform comes into effect. Special attention should be given to these issues in the state legislature to ensure that the interests of rural communities are protected.



## Endnotes

1. Medicaid waivers are essentially applications from states to the federal government requesting to ignore portions of the federal Medicaid law to better serve the needs of certain populations. The state will still receive federal funds for the additional programs.
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12. The PPACA uses the term “health home” specifically in this section of the bill.
13. Patient Protection and Affordable Care Act of 2010, HR 3590, 111<sup>th</sup> Cong., 2<sup>nd</sup> Sess (2010).
14. SB 966 was placed in the Appropriations Committee’s Suspense File as of May 12, 2010.
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CCRP welcomes opportunities to collaborate with community partners for more in-depth research on this topic.





The California Center for Rural Policy at Humboldt State University is a research center committed to informing policy, building community, and promoting the health and well-being of rural people and environments.

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