

Families Have Improved Access to Health Homes that Support Healthy Behaviors

OUTCOME TWO

Acknowledgments

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Using This Guide: A Note to Building Healthy Communities Coalition Leaders

Purpose

Each of the Building Healthy Communities *Outcome Resource Guides* is intended to provide a deeper understanding of the background and context for each outcome, a sampling of promising practices and strategies that will contribute to achieving each outcome, and additional tools and resources that can help local leaders plan for improving the health of their communities. These guides were written specifically to assist local leaders and planners in the 14 communities participating in the Building Healthy Communities program of The California Endowment.

Strategies and Promising Practices

The strategies and practices described in each guide are intended to provide options and spark new ideas for local planners. These lists and examples do not represent all known strategies and policy directions in the field. Rather, they represent an overall direction that, based on the evidence at hand, show promise for contributing to a comprehensive approach to improving health in California communities.

Indicators of Success

These indicators are examples of ways to measure changes in this outcome. The appropriate indicator to use as a part of measuring progress, either as a part of an evaluation or a performance monitoring plan, will depend on the targeted changes and strategies that are selected either as part of a Place's work plan or part measuring a grantee's performance.

Contributing to the knowledge base

These guides constitute the beginning of a TCE library of resources that will grow over the next 10 years based on the experiences of BHC communities, as well as on emerging evidence for promising policies and practices in the field as a whole. Community residents, local leaders as well as researchers and scholars are invited to add to this foundation as new tools, strategies, experience and evidence emerge. Please contact TCE at www.calendow.org.

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Outcome Two: Families Have Improved Access to Health Homes that Support Healthy Behaviors

I. Background

TCE’s vision of a healthy community includes health care services and systems which promote health. Over the ten years of our *Building Healthy Communities* plan, we hope that health care providers and systems in each of our fourteen places, as well as throughout the state of California, will provide high-quality health care services to local residents. We are calling such systems of care “health homes” – meaning health care providers who take care of children and families in a patient-centered and family-centered way. Ultimately, these health homes are where health is promoted, through linking and coordinating health care services with other services and support structures needed to maintain and improve health. Health homes would be essential but not sufficient in each place to improve that community’s health. Finally, we will need local, state, and national level policies to support the development and sustainability of such health homes.

II. Overview of Health Homes

Health homes are a relatively new and increasingly popular model for organizing and delivering patient-centered health care. Also called medical homes or patient-centered medical homes (PCMH), the approach typically involves primary care practitioners partnering with the patient and family to provide accessible, comprehensive, coordinated, family-centered, culturally competent, and prevention-oriented care. Since 2007, examples of this approach have been initiated by states, health plans, and collaboratives across the U.S. The federal government is soliciting applications from states to launch a Medicare medical home demonstration project (called an Advanced Primary Care model), scheduled to begin in 2010.

A Tale of Two Visits

Current System

After several days of waiting, eight-year-old Sam and his mother finally get in to see his pediatrician. Sam has been missing school lately because of a combination of colds and an ongoing asthmatic condition. When they arrive at the busy doctor’s office, they spend time updating their information in a crowded waiting room. After meeting with the physician for ten minutes, they receive an adjustment to Sam’s medication with verbal instructions on how to monitor his asthma. While Sam’s cold resolves, his asthma symptoms worsen to the point that Sam’s mother thinks she needs to take him to the emergency room one night.

Medical Home

The pediatrician’s office responds to an e-mail from Sam’s mother regarding Sam’s frequent school absences, suggesting that she set up an appointment that includes a meeting with one of their nurses. When they arrive for the appointment, they verify that all the information from the practice’s electronic medical record is correct. While meeting with the pediatrician to discuss Sam’s symptoms, the electronic medical record reminds the doctor that Sam is behind schedule for a needed immunization. Sam and his mother then meet with the practice’s nurse, who performs an asthma assessment and in the process learns that a temporary move to live with grandparents due to family problems may be aggravating his symptoms. Together, they draw up a written plan to help Sam manage his asthma. The nurse also mentions that the practice co-sponsors (with a local recreation department) a group of children with similar asthmatic conditions and suggests that Sam might want to join. The nurse follows up a week later to check on Sam’s progress and determines that he has met his goals for the week.

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History

The American Academy of Pediatrics (AAP) initially used the term “medical home” in 1967 to describe a central location for keeping a child’s medical records with a primary care provider (a pediatrician). The early focus was on children with special health care needs who typically had multiple, complex conditions. These children were often seen by many specialists and needed ongoing communication and coordination among all who were involved in that child’s care, including parents and family members. By 2002, AAP’s medical home concept was expanded to include accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

Encouraged by several large employers, four primary care physician organizations: the AAP, the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA), came together in 2007 to release the following Joint Principles of the Patient-Centered Medical Home (PCMH):

- A personal physician, typically a primary care physician
- Physician-directed medical practice
- Whole person orientation
- Care that is coordinated and/or integrated across all elements of the health care system (e.g., subspecialty care, hospitals, home health agencies, and nursing homes) and the patient’s community (e.g., family, public, and private community-based services).
- An emphasis and commitment on quality and safety
- Open scheduling, expanded hours, and new options for communication between patients, their personal physician, and practice staff

Additional refinements of the model have been added since 2007, including shared decision-making by the physician and patient/family, use of evidence-based decision support (using reminders about the best available research when making decisions about health care), and health information technology.

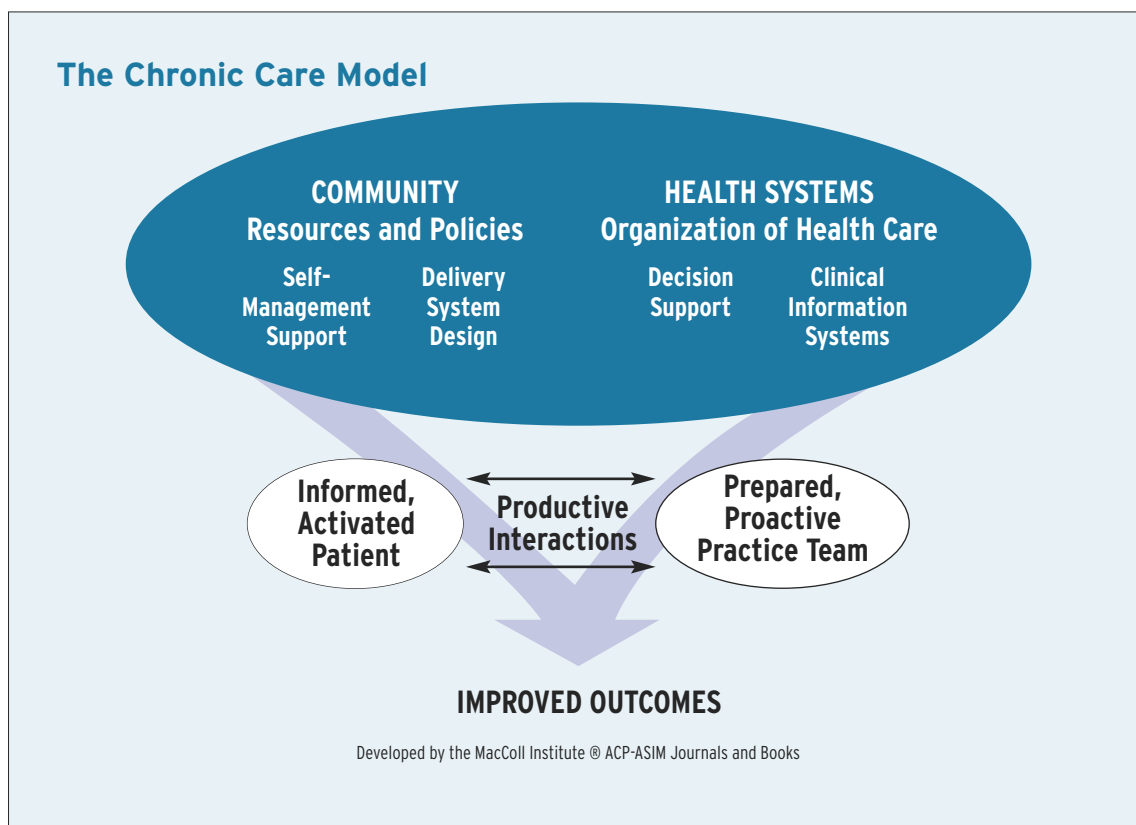
In 2008, America’s Health Insurance Plans (the national association representing health insurers) issued a statement describing eight core principles for the development and broad implementation of the PCMH, including comprehensive care, care coordination, use of health information technology, consumer education, development of payment methods that provide a more efficient, coordinated, and patient-centered experience, and pilot testing of approaches. In 2008, The American Medical Association (AMA) also endorsed the “Joint Principles of the Patient-Centered Medical Home.”

The health home model also incorporates lessons learned from another model of care called the chronic care model, developed by Dr. Ed Wagner at Group Health’s MacColl Institute for Healthcare Innovation in Seattle, Washington. This model involves six essential components:

- Creating a culture, organization, and mechanisms that promote safe, high-quality care
- Implementing health delivery system redesign
- Providing clinical decision support to health care providers
- Organizing information to facilitate care through effective information systems

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- Empowering and preparing patients to self-manage their health and health care
- Mobilizing community resources to meet patient needs



While the patient-centered medical home model is still evolving, it is being implemented and studied nationwide. For example, the Community Care of North Carolina Medicaid program saved approximately \$160 million annually after implementing medical homes, primarily through a 23% reduction in both emergency room visits and outpatient visits, and a reduction of 11% in pharmacy services. The program has also improved quality of care for patients with asthma and diabetes. Geisinger Health Systems in Pennsylvania has seen a 20% reduction in hospital admissions and across-the-board savings of approximately 7% in medical costs based on early pilot results. A recent study from Group Health Cooperative in Seattle showed a 29% reduction in emergency room visits, 11% fewer hospitalizations that appropriate primary care can prevent, 6% fewer in-person visits, and higher ratings on patient experience of care for patients in their medical home.

The Patient Centered Primary Care Collaborative (a coalition of employers, consumers, and health care providers) has published a compilation of patient-centered medical home pilot and demonstration projects, which can be accessed at http://pcpc.net/content/pcpcc_pilot_report.pdf

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The California Endowment is promoting a broader model of “health homes,” rather than “medical homes,” because of our emphasis on prevention and on using community assets, which include health care providers other than physicians. Some community health centers and others are beginning to use the term “health home” to describe a model of health care which is more community-based, highlights team-based approaches, and includes preventative services and linkages to other non-health services that support prevention, wellness, and health. Here are a few examples:

http://www.wcchc.com/Assets/Events/leadershipConf08/9_9_CHCH_2-3-09.pdf

Waianae Coast Comprehensive Health Center’s model of a Community Health Care Home

<http://apha.confex.com/apha/137am/webprogram/Session27641.html>

2009 American Public Health Association session on health homes

This Resource Guide will provide information and examples of promising strategies and practices related to the health home in the following four areas: 1) Integrated, Coordinated, and Comprehensive Care, 2) Family-centered Care, 3) Culturally Competent and Linguistically Accessible Care, and 4) High-quality Care. It will also address reimbursement and measurement issues and concludes with cross-cutting resources useful to those implementing health homes.

III. Promising Strategies and Practices

A. Integrated, Coordinated, and Comprehensive Care

A key component of a health home is that health care is integrated, coordinated, and comprehensive – that it seamlessly includes the range of clinical care, services, and providers needed by patients and their families (including prevention – a topic addressed in more detail in the Resource Guide for **Outcome 3**). Health homes ensure continuity of care for patients and families whenever they receive care outside the health home, such as when they are referred for specialty care, when they go to an emergency room or are hospitalized, or when they utilize the services of a community-based health organization (such as walking clubs). Health homes recognize and plan for the potential discontinuity in care that often occurs when patients are “handed off” within and between health care settings. Promising strategies and practices to implement integrated and coordinated care include health information technology, team-based care, integration of a broad range of professionals and services, use of community health workers, and a focus on connecting to the community.

Health Information Technology

A key strategy to ensure coordination within and between health care settings is the use of health information technology and particularly, the electronic medical record (EMR) or electronic health record (EHR). According to the federal National Alliance for Health Information Technology, an EMR is an electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization. (An EHR includes the same functions across health care organizations.) While uptake of EMRs is still

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relatively low in health care settings, interest in them has increased with the federal focus on health information technology under the American Recovery and Reinvestment Act of 2009.

A number of safety net providers have successfully integrated EMRs into their operations, including:

The Institute for Family Health (<http://www.institute2000.org/>) operates 16 health centers in New York City and the mid-Hudson valley of New York State. It is one of the first community health centers nationwide to implement an EMR. As a result, the Institute has significantly enhanced the quality of patient care through tracking systems, best practice alerts (electronic reminders of health strategies that have worked elsewhere), printable visit summaries, and increased compliance with preventive care guidelines. In addition, the Institute electronically works with the New York City Department of Health and Mental Hygiene's Surveillance System to supplement emergency room monitoring with data on Institute ambulatory visits in order to get an early view into disease outbreaks.

ACCEL: Access El Dorado Care Pathways (www.accelede.org) is a personalized care management program designed to increase access to primary and specialty care and establish "medical homes" for underinsured and uninsured children in El Dorado County in northeastern California. The underlying technology systems supporting this work include a centralized registry of patient demographic data and information from "6 Care Pathways" that lay out the steps for improving access to care in six areas such as securing child health care coverage and pediatric mental health. This information can be shared among authorized providers and includes a reminder system for ensuring that patient visits are completed.

Resources

Community Clinics Initiative (CCI) – Provides resources for community health centers and clinics
<http://www.communityclinics.org/>

National Health IT Collaborative for the Underserved
<http://www.omhrc.gov/npa/templates/content.aspx?lvl=2&lvlid=23&id=110>

Patient Centered Primary Care Collaborative (PCPCC): *IT Resource Guide*
<http://pcpcc.net/content/meaningful-connections-it-resource-guide>

Team-based Care

Team-based primary care is an emerging model of primary care practice in which one or more primary care physicians (PCPs) collaborate with multiple team members to develop and provide comprehensive, integrated treatment plans based on the needs of individual patients. This model is in contrast to the traditional, yet still prevalent, primary care practice with one or two PCPs assisted by a receptionist, a medical assistant, and a bookkeeper or billing clerk.

The new team-based model may include other primary clinicians such as physician assistants and nurse practitioners. Other potential team members include medical assistants, receptionists, schedulers (to arrange follow-up visits within the practice and with other medical practices and health facilities), care coordinators, health coaches/educators (to teach patients self-care techniques, health risk reduction, and lifestyle changes), and panel managers (who review the practice's disease

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registry and contact patients to schedule routine follow-up and preventive/diagnostic services appropriate to the individual patient’s history, age and gender). Some team-based models also include pharmacists, community health workers, social workers, and even appropriate staff from frequently used community-based services. Many staff are cross-trained to provide continuity and flexibility for the team. Perhaps the most important contributor to the team’s success is the team champion – a respected individual within the group who passionately advocates the group’s work as a team to achieve better quality outcomes for their patients. Finally, the patient’s needs and preferences should also be considered part of the team.

Potential Health Home Team Members

- The Patient
- Primary Care Physicians
- Physician Assistants
- Nurse Practitioners
- Medical assistants
- Receptionists
- Schedulers
- Care Coordinators
- Health Coaches/Educators
- Panel Managers
- Pharmacists
- Community Health Workers
- Social Workers
- Community-Based Services Staff

Kaiser Permanente/Georgia redesigned its primary care delivery system by developing over twenty primary care teams whose goals were to increase patient satisfaction, improve quality scores, and lower costs. Each team receives quarterly reports on patient and staff functioning and quality measures. The teams are independent and vary in their staff composition, and their approach to delegation. The management structure encourages physician “ownership” and team accountability, and leadership and staff are eligible for financial incentives based on the performance of the team. (<http://xnet.kp.org/permanentejournal/fall97pj/redesign.html>)

Community Care Teams are part of the Vermont Blueprint for Health, a statewide plan to improve the health and health care system for Vermonters (<http://healthvermont.gov/blueprint.aspx#annualrpt>). The teams provide multidisciplinary care support to patient-centered medical homes across a community, given that it is highly unlikely that the small practices participating as medical homes will have all the resources or expertise to address the social, economic, and behavioral issues faced by their patients and families. Insurers share the costs of the team that are comprised of nurse practitioners, social workers, behavioral specialists, community health workers, and public health specialists.

Resources

American Academy of Family Practice (AAFP): *The Practice Enhancement Forum* – a 2-day program that brings office teams together to participate in team development
<http://www.aafp.org/online/en/home/practicemgt/quality/cme/pef/goals.html>

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Bodenheimer, Thomas. "Building Teams in Primary Care: Lessons Learned and 15 Case Studies." California HealthCare Foundation. July 2007. <http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=133375>

Integrating Oral Health, Mental Health, and Other Services

Health homes involve the integration of a full range of health providers, including oral, mental, and vision health providers and aides. Many children have experienced tooth decay, vision problems, or have some type of mental health service needs. Left untreated, these conditions can result in a range of impairments with implications for growth and development and school performance. To address these concerns, health homes fully integrate the needs of patients and families in the critical areas of health care and overall health.

The Harris County (Texas) Community Behavioral Health Program was created in 2005 in collaboration with Baylor College of Medicine. Psychiatrists and psychotherapists were recruited, hired, and placed in the district's community health centers to work with primary care physicians, nursing staff, social workers, and substance abuse counselors. The program won a Gold Award from the American Psychiatric Association in 2007. (<http://psychservices.psychiatryonline.org/cgi/reprint/58/10/1366.pdf>)

The 11th Street Family Health Services Center in a medically underserved area of Philadelphia provides coordinated and integrated services, including primary care, behavioral health, and dental services to a patient base with over 50% Medicaid and 33% uninsured patients. Nurse practitioners are the primary care providers and are paired with a primary behavioral health specialist. This partnership provides integration of treatment approaches and can reach patients who might not access care in specialty mental health services. New staff members spend time in each clinical area (primary care, behavioral health, and dental services) so they understand the links among the three services in a comprehensive approach to care. (http://www.innovativecaremodels.com/care_models/16)

Resources

California Integrated Behavioral Health Project <http://www.ibhp.org/index.php?section=pages&cid=180>

Grantmakers in Health: *Critical Services for our Children: Integrating Mental and Oral Health into Primary Care*. February 2008. http://www.gih.org/usr_doc/Issue_Brief_30.pdf

National Council for Community Behavioral Healthcare: *Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home*. April 2009. <http://www.allhealth.org/BriefingMaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf>

National Institute for Health Care Management (NIHCM): *Strategies to Support Integration of Mental Health into Pediatric Primary Care*. August 2009. <http://nihcm.org/pdf/PediatricMH-FINAL.pdf>

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Connecting to the Community

In addition to integrating within and between medical practices, health homes also involve linkages with community organizations that provide services that support health and promote wellness. Health homes know about and work with community-based programs such as local health departments, school districts, law enforcement, family resource centers, child welfare organizations, park and recreation facilities, faith-based organizations, legal aid services, parent organizations, and disease-specific groups such as the American Diabetes Association. Linkages can involve community referral tracking systems or more formal partnerships that coordinate planning and implementation of programs addressing the needs of families. Often, health homes can connect to existing collaborative activities such as those noted below.

Potential Health Home Partner Organizations

- Local Health Departments
- School Districts
- Law Enforcement
- Family Resource Centers
- Child Welfare Organizations
- Park and Recreation Facilities
- Faith-based Organizations
- Legal Aid Services
- Parent Organizations
- Disease-specific Groups such as the American Diabetes Association

Help Me Grow – A Program of the Connecticut Children’s Trust Fund

(<http://www.211ct.org/programs/Helpmegrow.asp>) Help Me Grow works in collaboration with other organizations to implement a statewide network of services for young children who are at risk for developmental, health, or behavioral problems. The components of this program include a statewide toll-free number for accessing needed care, partnerships with community-based organizations, and child development community liaisons that serve as the conduit between the community-based services and the telephone access point. The program also involves a training component targeted at Connecticut child health providers, providing information about how to refer to Help Me Grow. Similar programs are available in Ohio and Orange County, California. (<http://www.helpmegrowoc.org/index.html>)

The Peninsula Family Advocacy Program Medical-Legal Partnership (FAP)

(<http://peninsulafap.org>) provides on-site legal services to support low-income families and pregnant women in addressing unmet legal needs that often present barriers to their children’s health outcomes. Pediatricians at Lucile Packard Children’s Hospital and Ravenswood Family Health Center (an East Palo Alto community health center), and healthcare providers at San Mateo Medical Center and its prenatal clinics are given instruction on legal issues affecting patients, and how to screen for family legal needs and then refer them to the Family Advocacy Program. Legal staff from the Legal Aid Society of San Mateo County are trained to work as part of the health care team, addressing issues such as housing, eligibility for public benefits programs, education, domestic violence, custody, and immigration. Since they are available on-site, these legal professionals

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are able to immediately start case files, educate families of their legal rights, and often provide solutions before a legal issue escalates to an emergency.

Resources

CA 211 – A directory of community services in most California counties. <http://www.ca.gov/211directory.html>

LA County Helps – Lists programs in a variety of areas in Los Angeles County. <http://lacountyhelps.org/>

National Center for Medical Legal Partnerships. <http://www.medical-legalpartnership.org/>

Community Health Workers

Community Health Workers (CHWs) are frontline public health workers who are trusted members of a community. This trusting relationship enables the CHW to serve as a liaison or intermediary between health and social service organizations and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through activities such as outreach, community education, informal counseling, social support, and advocacy. Other terms for similar functions include community health advisors, community health educators, lay health advocates, outreach educators, patient navigators, and promotores and promotoras.

The Monroe Plan (a Medicaid agency located in Rochester, NY), contracts with BabyLove, a prenatal social outreach program with dedicated, culturally competent outreach workers and social workers. The program includes home visits, development of a care plan, and additional support, such as transportation, as needed. The program has resulted in a substantial decrease in NICU admission rates for African-American teens. (<http://www.ncqa.org/Portals/O/HEDISQM/CLAS/posters/NICU.pdf>)

The Seattle-King County (WA) Healthy Homes II Asthma Project aimed to reduce exposure to indoor asthma triggers in several hundred low-income households with children ages three to thirteen through the use of CHWs. All participants received nurse-provided asthma education and referrals to community resources. Some participants also received CHW-provided home environmental assessments, asthma education, social support, and asthma control resources. The addition of CHW home visits to clinic-based asthma education yielded a clinically significant increase in symptom-free days and a modest improvement in caretaker quality of life. (<http://www.kingcounty.gov/healthservices/health/chronic/asthma/healthyhomes2.aspx>)

Resources

Community Health Worker National Education Collaborative (CHW-NEC)
<http://www.chw-nec.org/index.cfm>

Health Resources and Services Administration (HRSA): *Community Health Workers National Workforce Study*. March 2007. <http://bhpr.hrsa.gov/healthworkforce/chw/>

National Conference of State Legislatures: *Community Health Workers: Expanding the Scope of the Health Care Delivery System*. April 2008. <http://www.ncsl.org/print/health/CHWBrief.pdf>

Vision y Compromiso: The Community Health Worker (CHW)/Promotoras Network – Provides information about CHW/Promotora work in California. <http://cnet.sscnet.ucla.edu/community/promotoras/>

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B. Patient- and Family-Centered Care

Health homes are patient- and family-centered; they include the perspective of patients and their families and design care from that perspective. Patient- and family-centered health care providers collaborate with patients and families of all ages, at all levels of care, and in all health settings. They are respectful of, and responsive to, individual and family preferences, needs, and values, which ensures that these values guide all clinical decisions. Health care providers who are patient- and family-centered share complete and unbiased information with their patients in order to enable their effective participation in care and decision-making. They also encourage and educate patients to expand their role in health care decision-making through self-management and other engagement strategies.

Health homes also seek patient input on the physical aspects of receiving care from patients and families. They ask for recommendations on how to make their environments welcoming and accessible, plus ensure that the information required to receive care can be easily understood, is culturally relevant, and linguistically accessible (see following section).

Strategies to Make Health Homes Accessible

Access to care in a health home can be enhanced through a variety of techniques such as allowing same-day and weekend appointments, expanding hours to include before and after work, and using the Internet to expand access through e-visits and other online patient services. Shared medical appointments or group visits might be another way to expand access for some patients and families. Additionally, bringing services closer to where people live through community sites, mobile clinics, or other outreach activities may also increase accessibility.

After recognizing that patients faced long wait times to get an appointment, and then again in the waiting room prior to their appointment, the Second Street Family Practice in Auburn, Maine (part of the Sister of Charity Health System in central Maine) decided to make their practice more accessible. Now, many patients are seen the same day as a result of implementing advanced access scheduling – an approach to scheduling designed by Mark Murray, MD and Catherine Tantau, RN and initiated at Kaiser Permanente in Roseville, California. Advanced access uses queuing theory to reengineer the standard appointment scheduling system, leaving the majority of slots on any given day open for patients who call that day. (<http://www.ihl.org/IHI/Topics/OfficePractices/Access/ImprovementStories/AdvancedAccessReducingWaitsDelaysandFrustrationinMaine.htm>)

Mission Neighborhood Health Center (MNHC) in San Francisco is a Federally Qualified Health Center and a leader in advocacy efforts for culturally and linguistically competent health services for Latinos. MNHC offers the 10-session “Centering Pregnancy” group visit prenatal care model in monolingual Spanish. The sessions are led by nurse-midwives from San Francisco General Hospital and an MNHC social worker, health educator, and nutritionist. MNHC has found that the group approach fosters a network of social support among the mostly recent immigrants, as it increases the amount of clinician/patient contact time during pregnancy. (<http://www.mnhc.org/>)

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Resources

TransforMed Resources – Information to help improve access to physician offices
<http://transformed.com/resources/Access.cfm>

TransforMed Resources – Information concerning group visits
http://www.transformed.com/resources/Group_Visits.cfm

Strategies to Engage Patients and Families

Shared decision-making is an approach to the physician or health provider and patient/family relationship that ensures clinical and health decisions reflect a patient's preferences and values, rather than only the technical judgment of the health professional. In this style of counseling, the health care provider communicates personalized information about the options, outcomes, probabilities, and scientific uncertainties of available treatment options and the patient communicates his or her values and the relative importance placed on benefits or harms.

Shared decision-making often involves the use of “decision aids,” which are tools (such as pamphlets, computer programs, etc.) that help people become involved in a decision by supplying information about options and outcomes and by identifying personal values. Shared decision-making can be practiced in an individual clinician's office or embraced as an organization-wide or even statewide strategy.

The University of California, San Francisco Breast Care Center Decision Services unit (<http://www.ucsfhealth.org/adult/special/b/40527.html>) offers women with breast cancer an array of services, including 1) access to decision aids about breast cancer such as choosing surgery for early stage breast cancer or breast reconstruction, 2) pre-visit coaching on questions to ask their physician, 3) audio-recording of the discussion during the physician visit in order to have a complete record, and 4) generation of a written summary of the patient-physician discussion. The service is offered free of charge and can include accompaniment into the physician visit by a trained staff person such as a premedical intern, a pre-med college graduate who is working prior to attending medical school, or a social worker, nurse, peer cancer survivor, or other staff.

In 2007, Washington became the first state to explicitly endorse the use of shared decision-making (http://www.informedmedicaldecisions.org/washington_state_legislation.html). The legislation directs the state Health Care Authority to set up shared decision-making demonstrations in one or more group practice sites. Group Health Cooperative is implementing a shared decision-making pilot project. Researchers are working with twelve decision aids from the Foundation for Informed Medical Decision Making, including those on low back pain, breast cancer, and heart issues. They are experimenting with how to get the aids to patients (via Internet or mail), when to give them to patients (before a referral or after a visit), who should give them to patients, and which patients should receive them. Shared decision-making projects are also being implemented in the Seattle area at the Virginia Mason Clinic, Everett Clinic, Carol Milgard Breast Center, and Multi-Care. Other states that have expressed legislative interest in shared decision-making include Connecticut, Vermont, Minnesota, and Maine.

Clinical Areas in which Shared Decision-making Projects have been Developed

- ADHD
- Allergy
- Bronchitis
- Childbirth
- Ear infections
- Pregnancy
- Toilet training
- Tonsils and Adenoids

(Source: Ottawa Health Research Institute Decision Aids by Health Topic: <http://decisionaid.ohri.ca/AZlist.html>)

Resources

Center for Advancing Health: *Supporting Patient Engagement in the Patient-Centered Medical Home*. http://www.cfah.org/pdfs/CFAH_PACT_WhitePaper_current.pdf

The Cochrane Collaboration: *Decision Aids for People Facing Health Treatment or Screening Decisions*. <http://www.cochrane.org/reviews/en/ab001431.html>

Foundation for Informed Medical Decision Making – A national organization advancing research, policy, and clinical models of shared decision-making. <http://www.informedmedicaldecisions.org/>

Ottawa Health Research Institute (OHRI) – Information about patient decision aids <http://decisionaid.ohri.ca/>

Patient Self-Management

Patient self-management includes the many activities that focus on patients managing their own health care – generally outside formal medical institutions. It recognizes that people spend only a tiny percentage of time in the health care system and the majority of their lives by themselves, in their homes, at work or school, or in their communities. Patient self-management involves patients’ behaviors, knowledge, attitudes, feelings of self-efficacy (one’s belief that one is capable of performing in a certain manner to attain identified goals), and self-confidence about their ability to be well or to manage a chronic health condition. It includes such activities as learning how to monitor a health condition; making lifestyle changes; taking medications; avoiding, evaluating, and managing symptoms; making treatment adjustments; and learning how to overcome obstacles and problem-solve.

From the health professional’s perspective, patient self-management involves a holistic understanding of a patient’s life and a proactive rather than reactive response to patients. It includes the systematic provision of education and supportive interventions to increase patients’ skills and confidence in managing their health, regular assessments of progress and problems, goal setting, and problem-solving support.

In partnership with the University of Arizona, El Rio Community Health Center in Tucson, AZ (<http://www.elrio.org/programs.html>) developed a comprehensive, bilingual, bicultural program in 2001 that serves children with moderate or severe persistent asthma. The program identifies individual asthma triggers and provides parents and their families with the knowledge and tools to effectively manage their children’s asthma. A half-hour initial assessment is conducted with specially trained bilingual asthma counselors (MSWs, RNs, respiratory therapists, or nursing

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assistants.). An asthma action plan is developed that includes an asthma diary, individual and group educational sessions, and telephone follow-up at three, six, and nine months. Depending on need, the program might also provide equipment and supplies such as peak flow meters, nebulizers, mattress covers, and vouchers for pest control services.

Community Health Partners' (<http://www.chphealth.org/>) goal is to incorporate patient self-management into every encounter with every patient they see in their three community health centers in Montana. All staff members have been trained on multiple facets of patient-centered care, including motivational interviewing (a collaborative, patient-centered counseling approach to support patient behavior change), patient self-management techniques, and patient "teachback" (having patients repeat in their own words what they need to do after a clinician visit). When patients come in for an appointment, they are asked, "What is happening with you today?" and "What are your health goals for the future?" Together, they work through the issues and develop a plan with the outcome that patient's views have been "heard" during the encounter. The Center is equally committed to applying self-management principles to their own staff to keep them healthy and motivated. They also focus on the literacy and health literacy of patients and sponsor a literacy program, Learning Partners, which includes guidance from medical staff about the importance of reading aloud to children and an adult learning and literacy program.

Other community health centers have also participated in self-management support through the Health Resources and Services Administration's Collaboratives on Changing Practice. (<http://www.healthdisparities.net/hdc/html/about.hdcModels.aspx>)

Resources

California Health Care Foundation (CHCF) – Reports on Self-Management
<http://www.chcf.org/topics/chronicdisease/index.cfm?subtopic=CL613>

New Health Partnerships – A project of the Institute for Healthcare Improvement that provides information on patient self-management. <http://www.newhealthpartnerships.org/>

Stanford Patient Education Research Center – Sponsors programs and research on patient self-management. <http://patienteducation.stanford.edu/>

Personal Health Records

A personal health record (PHR) is an electronic, universally available, lifelong resource of health information needed by individuals to make health decisions. Individuals own and manage the information in the PHR, which comes from both health care providers and the individual. The PHR is maintained in a secure and private environment, with the individual determining the rights of access. They consolidate information historically available only in hard-copy form in various physician offices, labs, pharmacies, and other health care locations. PHRs generally include a health history (immunizations, surgeries, health conditions, lab tests, allergies, etc.), prescription drug information, medical/health provider contact information, health insurance, and patient-entered information/health journals. PHRs are different from Electronic Medical Records (EMRs) or Electronic Health Records (EHRs) that capture and store medical information within a health setting such as a hospital or physician's office or across health institutions.

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They can be available through a health insurance plan, a health provider's office, at a community or state level, or through the Internet, utilizing such products as Microsoft's Health Vault (<http://www.healthvault.com/>) or Google Health (<https://www.google.com/health>). Two challenges of this approach are assuring the privacy and security of personal health information, and addressing the needs of patients and families that do not have easy Internet access.

The Shared Care plan in Whatcom County, Washington (<http://www.patientpowered.org/>) is the result of collaboration between PeaceHealth St. Joseph Hospital, an information technology application company, Cangral, and the Whatcom Health IT Network – a regional health information organization that has electronically connected many of the providers in the area. The PHR was designed with patient input and includes sections on diagnoses, medications, medical history, plus innovative sections such as one that asks how users best like to learn (by reading, listening, demonstration, etc.). The plan can be pre-populated with information from area hospitals regarding medications, allergies, and immunizations. With recent funding from the Washington State Health Care Authority, the Shared Care Plan is now integrating their PHR with the Microsoft Health Vault platform as well as testing a variety of outreach strategies to increase community member usage. There is interest in creating a Spanish language electronic version that builds on a hard-copy Spanish version.

Health Shack (in cooperation with WIND Youth Services) in Sacramento, California (www.healthshack.info) is a pilot program that began in 2008 involving the design and implementation of a PHR for youth called "Health Shack." The youth have influenced the design of the PHR and worked with a public health nurse to enter information into it – thereby identifying gaps in their care and getting referred for follow-up. The PHR builds on the MiVIA (a PHR designed for migrant and seasonal workers in Sonoma Valley, California) platform – (<https://www.mivia.org/>), but also enables teens to include birth certificates, work history, social security numbers, and other important personal information. Access to the PHR is controlled by the youth.

Resources

American Health Information Management Assoc. (AHIMA): *My PHR* – Information for the public on PHRs. www.myphr.com

Markle Foundation: *Connecting for Health* – A public-private partnership working on health information technology, including PHRs. <http://www.connectingforhealth.org/>

Mathematica Policy Research, Inc.: *Personal Health Records: What Do Underserved Consumers Want?* May 2007. <http://www.mathematica-mpr.com/publications/PDFs/phrissuebr.pdf>

C. Culturally Competent and Linguistically Accessible Care

A key component of health homes is the delivery of care that is culturally competent and linguistically accessible – and that data is collected to prove it. There is a recognition that the growing diversity of the United States population ensures that health providers and organizations will confront new challenges as they care for patients from multiple backgrounds. There is also an awareness that understanding the needs of these patients

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and providing culturally and linguistically appropriate (CLAS) services have the potential to improve access to care and the quality of care, and to diminish current health disparities.

Culturally competent health systems are ones that are engaged with and responsive to diverse individuals and communities. Culture is defined broadly and includes race, ethnicity, national origin, primary language, age, sexual orientation, physical and mental ability, spirituality, and religion. Health homes can become more culturally competent by recognizing the importance of cultural differences among their patients and families, training workers to become familiar with how those differences may impact care-giving, matching health staff to populations served, assuring accessibility for certain population groups through office modifications and/or outreach, and working with community partners to address broader health issues.

In 2004, more than 5,000 Hmong refugees resettled in California after they were forced to leave their homes in Thailand. Many of the refugees had very limited access to health services in their homeland. To assist the special needs of this emerging community in California, The California Endowment developed and funded the Hmong Resettlement Health Project, which brought together a number of health and advocacy organizations in the Central and North State regions of California. Endowment funding helped ensure that the Hmong refugees settling in California had access to essential health and mental health care services. The Endowment also provided focused technical assistance on policy and advocacy to the Hmong Resettlement Project grantees to give them the skills to address the health and mental health needs of this new population. (<http://www.calendow.org/article.aspx?id=1486&ItemID=1486>)

In 2006, only seven percent of African American males in Detroit received preventive health exams. The “Check Up or Check Out!” program offered by Molina Healthcare of Michigan was designed to address the underutilization of preventive health care services among black males. Through specially designed personal outreach, education, and incentives, preventive exam rates increased from 7% to 19%, while testing rates for cholesterol, glucose, colorectal and prostate cancer doubled. The Molina program was one of several that won NCQA “Recognizing Innovation in Multicultural Health Care” awards. (http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLASInnovativePrac_08.pdf).

Resources

America’s Health Insurance Plans (AHIP): *Tools to Address Disparities in Health*
<http://www.ahip.org/disparities/QIModules/>

Beale, Anne C, et al. The Commonwealth Fund. *Closing the Divide: How Medical Homes Promote Equity in Health Care*. June 2007. http://www.commonwealthfund.org/usr_doc/1035_Beal_closing_divide_medical_homes.pdf?section=4039

Beal, Anne C. “Policies to Reduce Racial and Ethnic Disparities in Child Health and Health Care.” *Health Affairs*, 23(5), 2004: 171-179. <http://content.healthaffairs.org/cgi/reprint/23/5/171?ijkey=eW14LXKutZ37A&keytype=ref&siteid=healthaff>

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Health Resources and Services Administration (HRSA): *Cultural Competence Resources for Health Care Providers*. <http://www.hrsa.gov/culturalcompetence/>

National Quality Forum (NQF): *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competence*. http://www.qualityforum.org/Publications/2009/04/A_Comprehensive_Framework_and_PREFERRED_Practices_for_Measuring_and_Reporting_Cultural_Competyency.aspx

National Committee for Quality Assurance (NCQA): *Multicultural Health Care: A Quality Improvement Guide*. <http://www.clashealth.org/>

National Initiative for Children's Healthcare Quality (NICHQ): *Improving Cultural Competency in Children's Health Care: Expanding Perspectives*. July 2005. http://www.calendow.org/uploadedFiles/improving_cultural_competency_children.pdf

Linguistically Accessible Health Care

There is a great, and growing, need for language assistance services in California. Health services researchers have demonstrated that language barriers result in decreased patient comprehension, reduced adherence to treatment regimens, and lower patient satisfaction. Language barriers also have been associated with increased risk of medication errors, longer emergency room stays, and higher medical costs. Several research studies suggest that providing trained interpreters can improve the quality and decrease the cost of care.

United Healthcare Latino Health Solutions (<http://www.uhclatino.com/>), a division of the United Healthcare health plan, recognized that Hispanics are the fastest-growing segment of the U.S. workforce and many Hispanics, while speaking English at work, prefer to speak Spanish at home, and rely on Spanish when dealing with complicated or personal topics like health care. To make certain that Spanish-preference members receive the same quality of service as English-speaking members, the company implemented an Enhanced Bilingual Service and Member Access Initiative. The goal of this initiative was to improve access to and quality of Spanish-speaking members' interactions with the health plan. The initiative included improving members' ability to select and access providers' offices that have a required language capability and supporting members through trusted, in-language customer care professionals who can help them understand plan policies and the health care system.

Kaiser Foundation Health Plan, recognizing the lack of translated materials as well as the unverified quality of those materials that were available, implemented the National Standardized Quality Translation Initiative. In this initiative, Kaiser proactively addressed its clinical demand for translated materials by implementing translation projects and retrospectively analyzing and assessing these materials to inform recommendations for quality improvement. Through this work, Kaiser Permanente standardized a quality translation process and infrastructure and created a centralized repository of translated information in order to develop a virtual translation management environment. In this virtual environment, the standardized translation process can potentially become broadly accessible, facilitating universal access to all Kaiser Permanente regions, as well as external health care organizations and public institutions. As a result of their efforts,

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Kaiser Permanente has also developed and disseminated Health Care Glossaries in six languages: Spanish, Chinese, Vietnamese, Korean, Armenian, and Russian, providing standard translations of difficult-to-translate health care terms and phrases.

http://www.ncqa.org/Portals/0/HEDISQM/CLAS/posters/Kaiser_Translations.pdf

Resources

California Health Care Safety Net Institute – *Straight Talk: Model Hospital Policies and Procedures on Language Access*. <http://www.safetynetinstitute.org/content/Upload/AssetMgmt/Site/Publications/documents/StraightTalkFinal.pdf>

The Joint Commission: *Hospitals, Language, and Culture* – Research studies and information for hospitals regarding language access and cultural needs <http://www.jointcommission.org/PatientSafety/HLC/>

Medical Leadership Council on Cultural Proficiency (MLC): *Language Access, Cultural Proficiency and Workforce Diversity*. <http://www.medicaleadership.org/>

Collecting Data on Race and Ethnicity

A key component of understanding whether a health home is providing culturally competent and linguistically accessible health care is the ability to collect data that identifies disparities in care received by different populations. Valid and reliable data are important building blocks for identifying care differences, developing targeted interventions to address gaps, and monitoring improvement.

Wellpoint, Inc., a health plan servicing over 35 million members in several states, wanted to address a lack of self-reported race and ethnicity information among its membership. With support from the RAND Corporation, the plan developed a means to indirectly derive this information, utilizing a model that combined geocoding, name analysis, and logistic regression. The resulting data enabled comparison of health plan performance by race and ethnic group. Overlaying the performance data with geographic software produced maps showing health disparity “hotspots,” supporting planning for improved service and access (http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLASInnovativePrac_08.pdf, page 18)

Contra Costa Health Plan has developed a set of race, ethnicity, spoken language, and written language categories applicable to its service population. The most frequently encountered categories are recognized by keystroke in the computerized patient data system and staff is provided training on how best to obtain this demographic information from patients. (See Appendix H, Institute of Medicine – *Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement*. 2009.) (http://books.nap.edu/openbook.php?record_id=12696&page=223)

Resources

Health Research and Educational Trust (HRET): *HRET Disparities Toolkit*. <http://www.hretdisparities.org/>

Institute of Medicine (IOM): *Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement*. August 2009. <http://www.iom.edu/CMS/3809/61110/72796.aspx>

National Health Plan Collaborative (NHPC) – Toolkit to help other health plans reduce disparities in healthcare for their memberships http://www.nationalhealthplancollaborative.org/500_toolkit.html
 RAND: *Q-DART: Innovative Solutions to Target Gaps in Health Care Quality and Health Outcomes* – Analytic tools to generate data on health care disparities in diverse populations
<http://www.rand.org/health/projects/qdart/>

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Workforce Diversity/Allied Health Professions

Health homes employ professional and allied health staff who reflect the diversity of their patients and families. Research demonstrates that the supply and composition of the health workforce are key ingredients in maintaining and improving the health status of individual patients from diverse communities. A study in the American Journal of Public Health found that minority physicians are “significantly more likely than other physicians to care for medically underserved populations.” Another study published found that African-American and Latino health professionals were significantly more likely to care for patients with family incomes below the poverty level. Moreover, a diverse health workforce has been associated with improved cultural competency, patient trust, and compliance to treatments. A challenge faced by health homes is the shortage in many allied health professions (which provide good entry-level jobs) of potential career and educational ladders into other positions in health care. These positions also tend to more closely reflect the demographic diversity of the local population.

An allied health professional is “a health professional (other than a registered nurse or physician assistant) who has received a certificate, an associate degree, a bachelor’s degree, a master’s degree, a doctoral degree, or postbaccalaureate training in a science related to health care; who shares in the responsibility for the delivery of healthcare services or related services, including services relating to the identification, evaluation, and prevention of disease and disorders, dietary and nutrition services, health promotion services, rehabilitation services, or health systems management services.” *Section 701 of the Public Health Service Act of 1992.*

Welcome Back INITIATIVE: The purpose of this statewide initiative is to build a bridge between the pool of internationally trained health workers living in California and the need for linguistically and culturally competent health services in underserved communities. To accomplish this goal, the Welcome Back INITIATIVE provides program participants with counseling, education, and support in obtaining the appropriate professional credentials and licenses required to work in the U.S. health care system. (<http://www.e-welcomeback.org/>)

Connecting the Dots: This is a California statewide initiative that is led by the UC Berkeley School of Public Health and the Public Health Institute to increase health professions workforce diversity. This project included a quantitative assessment of the diversity in California health professions and professional schools; documentation of over thirty exemplary practices in areas such as admissions, institutional climate, and reduction of financial barriers; focus groups with health profession students; and an examination of K-12 networks to support an educational pipeline for the health professions. (<http://www.calendow.org/Article.aspx?id=2290>)

Resources

The California Endowment Resources on Workforce Diversity: *Allied Health Workforce Analysis* http://www.calendow.org/Collection_Publications.aspx?coll_id=30&ItemID=320

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Help Wanted: *Will Californians Miss out on a Billion-Dollar Growth Industry?* – A report on allied health workers in California. <http://www.calhealthjobs.org/help-wanted-report>

Praxis Project: *If It's a Pipeline, Why Isn't There More Diversity at the Other End?: Framing the Agenda for Health Professions Workforce Diversity.* http://www.thepraxisproject.org/tools/if_it_is_a_pipeline.pdf

Center for the Health Professions at University of California San Francisco – Publications and Resources on workforce, health systems, policy, access, and quality issues <http://futurehealth.ucsf.edu/Public/Publications-and-Resources.aspx>

D. High-quality Care

Health homes provide care that is high-quality and safe – outcomes that cannot be assumed in today's health care system. A study of twelve large communities produced in 2004 and reported in the *New England Journal of Medicine* found that nearly half of the people in those communities were not getting the care recommended for their condition. A 2006 report from the Institute of Medicine found that medication errors harm at least 1.5 million people every year. High-quality care is based on the latest evidence from medical research about what types of care work best; is provided by skilled professionals; and is safe, timely, effective, efficient, equitable, and patient-centered..

Providing Appropriate and Evidence-based Care

There are a variety of ways to ensure appropriate and evidence-based care in health homes, including clinical decision-support tools that provide information about medical evidence or clinical guidelines to health care providers at the point in care delivery when it is most relevant. These include medication management systems to insure proper understanding and use of patient medications. Some organizations also use disease registries – databases that keep track of patients with a certain condition or disease to monitor whether they are receiving needed care. If they are not receiving that care, they have mechanisms to reach out to those patients. Providers in health homes also understand that in some cases, the best care involves “watchful waiting” and approaches that reflect the values of patients and their families.

Researchers at the University of Michigan Medical School transformed the way health care services were delivered at their family practice clinics, using an electronic clinical reminder and tracking system designed to support evidence-based quality improvement efforts. Staff is able to produce a customized checklist for each patient visit, indicating what services are due, document diagnoses and problems, and record actions taken. These changes have improved preventive and chronic disease management scores, in part by empowering staff to take the initiative in providing necessary services before the physician sees the patient. (<http://www.innovations.ahrq.gov/content.aspx?id=1771>)

The Commonwealth Fund, Qualis Health, and the MacColl Institute for Healthcare Innovation at Group Health Research Institute have launched an initiative to help primary care safety net clinics become high-performing patient-centered medical homes. Working with five regional coordinating councils in Colorado, Massachusetts, Idaho, Oregon, and Pittsburgh, who in turn partner with twelve to fifteen safety clinics, the project will focus on a number of practice changes, including the provision of evidence-based care, using point-of-care reminders, and other strategies to make

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up-to-date information available to the care team at the time of a patient's visit. Other aspects of change will focus on developing a quality improvement strategy, care coordination, enhanced access, and engaged leadership. (<http://www.qhmedicalhome.org/safety-net/>)

Resources

Agency for Healthcare Research and Quality (AHRQ) Effective Health Care Program – A website providing information about comparative effectiveness research. <http://effectivehealthcare.ahrq.gov/>

The Center for Improving Medication Management. <http://www.thecimm.org/>

The Cochrane Collaboration – An international non-profit organization that produces systematic reviews of health care interventions. <http://www.cochrane.org/>

National Guideline Clearinghouse – A resource for evidence-based clinical guidelines <http://www.guideline.gov/>

National Quality Forum (NQF) – A national organization that endorses national standards for measuring and publicly reporting on health care performance. <http://www.qualityforum.org/>

US Preventative Services Taskforce – An independent panel of experts in primary care that reviews the evidence of effectiveness and develops recommendations for clinical preventive services <http://www.ahrq.gov/CLINIC/uspstfix.htm>

Quality Improvement

Health homes embrace the concepts and strategies of quality improvement and continuously strive to improve the care they provide. Borrowing techniques from the manufacturing sector, quality improvement often involves ongoing cycles of planning, implementation, and assessment, repeated over and over. It is heavily reliant on measurement, buy-in, and participation from all levels of staff. It is most successful when embedded as part of the organizational culture, rather than as a separate task or responsibility. Increasingly, external accrediting and certification organizations such as The Joint Commission (which accredits hospitals and other health organizations), NCQA (which evaluates managed care plans and medical groups), and physician organizations such as the American Board of Internal Medicine, are looking for evidence of quality improvement as part of their oversight activities. For visual schematic of one healthcare improvement model, see <http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/>.

In order to improve access to high-quality care for underserved, uninsured, and underinsured Americans, the U.S. Health Resources and Services Administration (HRSA) has sponsored collaboratives to improve primary care and eliminate health disparities since 1998. Working first with one Primary Care Association/Clinical Network team in each of five regional clusters, HRSA has worked with over 800 community health centers. Areas of focus include asthma, business case redesign, cancer screening and planned care, management and treatment of depression, oral health, patient safety, prevention, diabetes, cardiovascular disease, and organ donation and transplantation. A wide range of collaborators includes the Institute for Healthcare Improvement (IHI), Centers for Disease Control and Prevention, National Association of Community Health Centers, and the Healthcare for the Homeless Clinicians Network. (<http://www.healthdisparities.net/hdc/html/home.aspx>)

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Building Clinical Capacity for Quality (BCCQ) is a Southern California initiative designed to enhance the capacity of community clinics to implement quality improvement strategies that are supported by health information technologies. BCCQ started by conducting an assessment of 51 safety net organizations' readiness for technology-enabled quality improvement – finding that the majority were not prepared. To address these needs, a Technology-Enabled Quality Improvement program was designed to support clinics in implementing one quality improvement project. Program supports included participation in a learning collaboration, stipends for software purchase, and technical assistance. (http://www.unihealthfoundation.org/pdfs/uhf_bccqreport1.pdf)

Resources

American Board of Internal Medicine Practice (ABIM) Improvement Modules – Web-based tools that enable physicians to conduct self-evaluation of care they provide. <http://www.abim.org/pims/>

Institute for Health Care Improvement (IHI) – An independent non-profit that helps health care institutions improve health care. <http://www.ihl.org/>

The Joint Commission – Accredits hospitals and other health care institutions <http://www.jointcommission.org/>

National Assembly on School-based Health Care (NASBHC) – Quality improvement information and tools. http://www.nasbhc.org/site/c.jsJPKWPFJrH/b.2719357/k.6312/EQ_Quality_Improvement.htm

National Committee for Quality Assurance (NCQA) – Accredits managed care plans and other health providers. <http://www.ncqa.org/>

Reimbursement and Payment Issues

Development of the health home may require new forms of reimbursement for health professionals and organizations. The focus on coordinated, patient-centered health care takes time, investment in new technologies, changes in workflow and required skills, and new or enhanced job specifications for staff of health care providers and organizations. The American Medical Association offered a framework for thinking about payment in their Joint Principles of the Patient Centered Medical Home (<http://www.ama-assn.org/ama1/pub/upload/mm/368/medical-home.pdf>). Payment approaches should:

- Reflect the value of physician and non-physician work that falls outside the face-to-face visit.
- Include pay for services associated with coordination of care both within a practice and between other providers and the community.
- Support the adoption and use of health information technology.
- Support the provision of enhanced communication access such as secure e-mail and telephone consultation.
- Allow payments for achieving measurable and continuous quality improvements.

The Patient-Centered Primary Care Collaborative proposed a three-part model for reimbursement for patient-centered medical homes (<http://pcpcc.net/content/proposed-hybrid-blended-reimbursement-model>):

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- A prospective monthly care coordination payment for the work that falls outside of a face-to-face visit and for the health information technologies needed to achieve better outcomes
- A visit-based fee similar to current reimbursement
- A performance-based component that recognizes achievement of quality and efficiency goals

These are important policy issues that will need further exploration, research, and advocacy to support the implementation and sustainability of health homes.

IV. Measuring Progress Towards A Health Home

There are several efforts to measure progress toward becoming a health home. The American Academy of Pediatrics and TransforMED (a subsidiary of the American Academy of Family Physicians) have developed resources to self-assess an organization's status as a medical home. NCQA has developed a Physician Practice Connections–Patient-Centered Medical Home recognition program. The program measures access and communication, patient tracking and registry functions, care management, patient self-management support, electronic prescribing, test tracking, referral tracking, performance reporting and improvements, and advanced electronic communications. Those meeting the requirements are recognized as PCMHs.

From a patient experience perspective, there are several measurements that may be relevant, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS) that measures patients' experiences with ambulatory and facility level care and the Patient Activation Measure (PAM), a tool that assesses the knowledge, skills, and confidence of managing one's health and healthcare – developed at the University of Oregon and now available commercially.

Another area of policy development will be the integration of these patient-experience measures in the overall measures and assessments of health homes.

Resources

American Academy of Pediatrics (AAP): *Medical Home Measurements*
http://www.medicalhomeinfo.org/tools/med_home.html

Agency for Healthcare Research and Quality (ARHQ): *Consumer Assessment of Healthcare Providers and Systems (CAHPS)*. <https://www.cahps.ahrq.gov/>

National Committee for Quality Assurance (NCQA) Physician Practice Connection – Patient-Centered Medical Home Recognition Program. <http://www.ncqa.org/tabid/631/Default.aspx>

Insignia Health – Patient Activation Measure (PAM). <http://www.insigniahealth.com/ha/measure.html>

TransforMED Online Self-Assessments. <http://www.transformed.com/self-assessments.cfm>

V. Resources

While each of the strategies discussed above help move health care providers closer to becoming a health home, there are a number of resources that provide cross-cutting help in implementing health homes. They include:

American Academy of Pediatrics (AAP): *The National Center of Medical Home Initiatives for Children with Special Health Needs*. <http://www.medicalhomeinfo.org/>

American College of Physicians (ACP) – Medical Home Builder tool (available for a fee)
http://www.acponline.org/running_practice/pcmh/help.htm

California Academy of Family Physicians (CAFP): *The Patient Centered Medical Home*
<http://www.familydocs.org/practice-resources/pcmh.php>

National Partnership for Women & Families – Patient Centered Medical Home information
http://www.nationalpartnership.org/site/PageServer?pagename=ourwork_medicalhome_landing

Patient-Centered Primary Care Collaborative – A coalition of employers, consumer groups, and health providers who are advancing the patient-centered medical home. <http://pcpcc.net/>

Primary Care Development Corporation (a nonprofit organization interested in primary care in underserved communities): *Obtaining Patient-Centered Medical Home Recognition: A How To Manual*
http://www.pcdcny.org/index.cfm?organization_id=128§ion_id=2047&page_id=8777

TransformMED (a subsidiary of the American Academy of Family Physicians)
<http://transformed.com/index.cfm>

UCLA Center for Health Policy Research Brief: *Health Coverage in the Safety Net: How California's Coverage Initiative is Providing a Medical Home to Low-Income Uninsured Adults in 10 Counties, Interim Findings*. June 2009. <http://www.healthpolicy.ucla.edu/pubs/Publication.aspx?pubID=364>