Connecticut Health FOUNDATION

Policy Brief

Advancing Health Equity Through Medical Homes

July 2012

IN SUMMARY

- **Increasing evidence shows that establishing medical homes can improve health outcomes, advance health equity, and potentially reduce costs. Many health plans and employers, most states, and the federal government are implementing activities to establish medical homes.**

- **Most medical home initiatives use the National Committee for Quality Assurance (NCQA) standards for patient-centered medical homes (PCMH)[1]. The NCQA is an independent non-profit organization that manages voluntary accreditation programs for physicians, health plans, and other health care organizations.**

- **There are six NCQA standards for patient-centered medical homes:**

  1. **Enhancing access to and continuity of care.**
     Especially important to racial and ethnic minority populations, who are the least likely to have regular sources of care.

  2. **Identifying and managing patient populations.**
     Viewing patients as a whole "panel" or population, primary care providers can more readily identify which patients may need more attention.

(continued)

OVERVIEW

The idea of the medical home

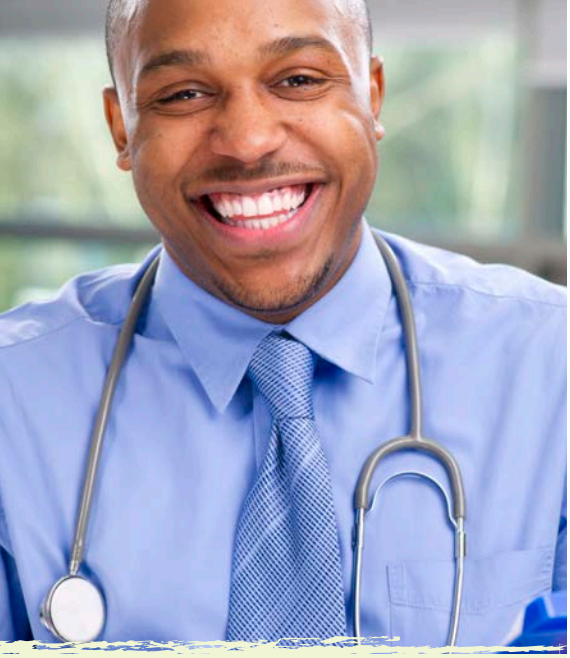
Medical homes are trusted home bases where individuals have ongoing relationships with primary care physicians who provide and coordinate all needed care, and with whom they work together on maintaining health.

While the ideal of an ongoing relationship with a physician who provides and coordinates care has existed for nearly 50 years, increasing evidence shows that establishing medical homes can improve health outcomes, advance health equity, and potentially reduce costs. Many health plans and employers, most states,[2] and the federal government[3] are implementing activities to establish medical homes.

The importance of health equity

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

Disparities in how health care is provided, and differences in circumstances that affect how healthy some patients are, weaken communities by unfairly burdening certain groups. In addition, when some have less access to good care, don't have illnesses properly diagnosed, or don't have access to treatment until they are sicker, health care costs rise for everyone.



IN SUMMARY

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3. **Planning and managing care.** An individualized care plan for each patient is, ideally, developed with the patient (and family members and caregivers when appropriate), who shares decision-making about the plan.

4. **Providing self-care and community support.** Information, tools, and support are needed to encourage self-management of diseases or conditions during patients' daily lives.

5. **Tracking and coordinating care.** A role of the medical home is to coordinate — and proactively keep track of — care provided by other professionals and, when needed, to follow-up with both patients and other providers.

6. **Measuring and improving performance.** Having demographic data on the race, ethnicity, and language of patients will enable the quality data to be stratified, and any disparities to be identified and addressed.

How medical homes can advance health equity

Medical homes will customize and improve care by making sure that doctors know their patients well, have access to their patients' medical histories and records, and can share information in ways that will enable patients to take better care of themselves.

This policy brief is organized according to the most commonly used standards for medical homes from the National Committee for Quality Assurance (NCQA), highlighting the opportunities to advance health equity through the establishment of medical homes. While medical homes will improve the quality of health care for all patients, emphasizing these elements of the medical home for racial and ethnic minority patients — who have encountered barriers to care — can make significant contributions to achieving health equity.

INTEGRATING HEALTH EQUITY INTO THE MEDICAL HOME

Enhancing access to and continuity of care

Enhanced access to and continuity of primary health care will be especially important to racial and ethnic minority populations, who are the least likely to have regular sources of care.

- Establish medical homes for racial and ethnic minority individuals, matching their preferences for providers when feasible.
- Ensure language access at all points of service, including after-hours care.
- Provide multiple channels and formats of communication between the primary care provider (and care team), and the patient (and patient's family and caregivers, when authorized by the patient and when appropriate) by phone, mail, Internet, mobile phones/smart phones, etc.[4]

Identifying and managing patient populations

When primary care providers view all their patients as a whole "panel" or population, they can more readily identify who may need more attention, countering the inclination of many physicians to "treat all patients exactly the same." Patients with chronic conditions, those with multiple conditions, those with other risk factors — (patients of color are more likely to fall into these categories) — generally need more tailored care than relatively healthier patients.

- Collect, document, and use demographic data to identify patient needs and monitor disparities.[5]
- Identify quality measures where state and national data show persistent disparities (e.g., infant mortality, asthma, diabetes care)[6] and analyze for disparities within the medical home practice.
- Identify and implement culturally and linguistically appropriate interventions that improve health care quality among diverse patient populations, and decrease disparities.

Health equity means achieving the same levels of health care quality, health care outcomes, and health status among all population groups.

Planning and managing care

A "best practice" that is seldom implemented is the development of an individualized care plan for each patient, ideally developed with the patient (and family members and caregivers when appropriate). For racial and ethnic minority patients, individualized care plans will ensure that the care provided by the medical home is culturally and linguistically appropriate.

- Develop a culturally and linguistically appropriate care plan with each patient, and when appropriate, the patient's family and caregivers.
- Provide culturally and linguistically appropriate support to patients, families, and caregivers involved in shared decision-making, and sending culturally and linguistically appropriate reminders about preventive care, chronic care, and prescription medications.
- Ensure that all communications, and shared decision-making processes and support, are appropriate for patients with all levels of health literacy.

Providing self-care and community support

Patients, their families, and caregivers need culturally and linguistically appropriate information, tools, and support to implement care plans and encourage self-management of diseases or conditions during patients' daily lives outside of clinical care settings.

- Support patient self-management with culturally and linguistically appropriate education, and self-management tools and resources that are appropriate for patients at all levels of health literacy.
- Share and make readily accessible the patient's health information (and when authorized and appropriate, the patient's family and caregivers) through multiple channels and formats (translation and medical interpreter services, addressing health literacy, using Internet and mobile health communications technologies).
- Identify and establish strong linkages and referrals to culturally and linguistically appropriate enabling services (e.g., medical interpreter and translation services, transportation, case management) and to culturally and linguistically appropriate community-based services.

Tracking and coordinating care

Pharmacies, labs, hospitals, specialty clinicians, health educators, providers of other clinical services (such as dentists and optometrists), and other professionals are all essential to quality health care. For racial and ethnic minority patients who face barriers to access and often need more complex care, this coordination and follow-up with both patients and other providers is especially important.

- Track referrals with both patients and other providers to ensure culturally and linguistically appropriate care and services.
- Review all medications and explain medication use to the patient after each referral, hospitalization, or change in care plan, ensuring that language assistance and health literacy needs are addressed.
- Coordinate transitions of care, sharing and obtaining summaries of care from specialists, hospitals, and other health care providers, and ensuring that language assistance and health literacy needs are addressed.

Measuring and improving performance

Medical homes have built-in measurements that will document factors like access, coordination, patient engagement, and patient experience, as well as health outcomes. Having demographic data on the race, ethnicity, and language of patients will enable the quality data to be stratified, and disparities to be identified and addressed.

- Stratify analyses of all internal and public reporting of quality data by race, ethnicity, and language.
- Oversample vulnerable patients and patients from disparities populations about their experiences of care in surveys.
- Include disparities reduction in all quality improvement goals, objectives, and activities.
- Engage diverse patients as quality improvement advisors and members of quality improvement teams.

SUPPORTING HEALTH EQUITY: WHAT STAKEHOLDERS CAN DO

Many opportunities exist for interested parties to support the improvement of health care delivery and health outcomes that the medical home model offers. The following activities can help ensure that health equity is fully integrated into ongoing quality improvement activities:

For patient and consumer advocates

- Identify ways that patients and consumers can become more educated and engaged in the establishment of medical homes and in health care quality improvement.
- Explain and promote the importance of the self-reporting of race, ethnicity, and language demographic data.
- Advocate for the collection and use of more disaggregated ethnicity data categories relevant to each state.
- Request and monitor stratification of publicly reported quality data by race, ethnicity, and language.
- Advocate for, and monitor progress toward, specific goals and objectives to reduce disparities in medical home quality improvement activities.

For health plans, employers, administrative services organizations, and others sponsoring and implementing medical home activities

- Train clinical and office staff on standards and best practices for culturally and linguistically appropriate care.[7]
- Support health care providers in collecting complete, accurate, and self-reported data on race, ethnicity, and language.
- Train providers on best practices in interventions to improve the quality of health care for racial and ethnic minority populations and reduce disparities.[8]
- Require public reporting of medical home quality measures, including patient experience of care, stratified by race, ethnicity, and language.
- Include disparities reduction goals and objectives in all quality improvement activities.

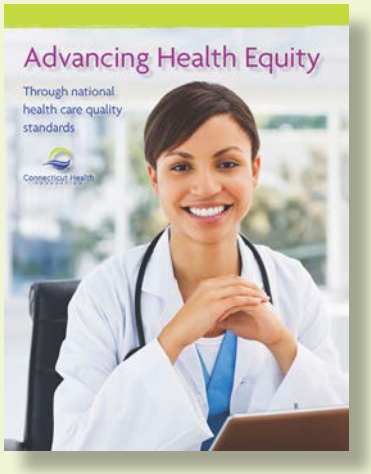
For state Medicaid programs implementing medical homes

- Ensure access to medical homes for all Medicaid beneficiaries, especially those with limited English proficiency.
- Support the collection of more disaggregated ethnicity data appropriate to the state by creating a template of disaggregated ethnicity categories.
- Seek federal matching funds for medical interpreter and other language assistance services.[9]

For funders and public policy advocates

- Support education and training of providers, and of patients and consumers, on the concept of the medical home and how it can advance health equity.
- Explain and promote to patients and consumers the importance of the self-reporting of race, ethnicity, and language demographic data to identify and reduce disparities.
- Support identification, training, and peer technical assistance for patient and family quality improvement advisors in individual practices, physician groups, community health centers, and other primary health care provider organizations implementing medical homes.[10]
- Highlight opportunities to advance equity through the implementation of medical homes through publications and other communications.
- Monitor medical home-related quality improvement activities and reports, including patient experiences of care, to ensure that disparities reduction goals and objectives are included.

Implementation of medical homes holds the promise of making progress toward achieving the triple aim of improved patient experiences of care, improved population health, and reduced health care costs.[11] Quality improvement is especially important for racial and ethnic minority populations, who continue to experience disparities in health care and health outcomes. Integrating the advancement of health equity into the establishment of medical homes will improve health care quality for all U.S. residents.



The accompanying publication lists national standards being used by health care providers to measure progress in health care quality improvement, including standards for patient-centered medical homes, and highlights the elements of these standards that provide opportunities to advance health equity.

Changing Systems, Improving Lives.

MORE INFORMATION

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FOOTNOTES

1. National Committee for Quality Assurance, Patient-Centered Medical Home Recognition (2011), see: http://www.ncqa.org/tabid/631/Default.aspx

2. Takach M. Reinventing Medicaid: State innovations to qualify and pay for patient-centered medical homes show promising results. Health Affairs 2011; 39(7):1325-1334

3. For example, in October 2011, the U.S. Department of Health and Human Services (HHS) began a medical home initiative for Federally Qualified Health Centers (FHQCs), supporting 500 FQHCs to become medical homes over the next two years. Optimus Health Care in Bridgeport and Community Health & Wellness Center in Torrington are the two FQHCs in Connecticut selected to participate in this federal HHS initiative. See, http://www.fqhcmedicalhome.com/welcome.aspx

4. Millery M, Kukafka R. Health information technology and quality of health care: Strategies for reducing disparities in underresourced settings. Medical Care Research Review (2010); 67(5 Suppl):268S-298S; Bau I. Connected for health: The potential of health information and communications technologies to reduce health care disparities. National Civic Review (2011); 100(3):15-18

5. Health Research and Educational Trust, Disparities Toolkit (2007), see: http://www.hretdisparities.org; Institute of Medicine, Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement (2009), see: http://www.iom.edu/datastandardization

6. National Quality Forum, National Voluntary Consensus Standards for Ambulatory Care: Measuring Healthcare Disparities (2008), see: http://www.qualityforum.org/Publications/2008/03/National_Voluntary_Consensus_Standards_for_Ambulatory_Care%E2%80%94Measuring_Healthcare_Disparities.aspx

7. U.S. Department of Health and Human Services Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services (2000), see: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15; National Quality Forum, Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competence (2009), see: http://www.qualityforum.org/projects/cultural_competency.aspx

8. Washington DL, Bowles J, Saha S, Horowitz CR, Moody-Ayers S, Brown AF, Stone VE, Cooper LA. Transforming clinical practice to eliminate racial-ethnic disparities in healthcare. Journal of General Internal Medicine (2008);23(5):685-91; Chin MH, Walters AE, Cook SC, Huang ES. Interventions to reduce racial and ethnic disparities in health care, Medical Care Research and Review (2007); 64(5 Suppl):7S-28S

9. Connecticut Health Foundation has commissioned research on medical interpretation, see: http://tinyurl.com/cugx8pj; http://tinyurl.com/7y72cxh

10. Institute for Family- and Patient-Centered Care, Partnering with Patients and Families To Design a Patient- and Family-Centered Health Care System: Recommendations and Promising Practices (2008), see: http://www.ipfcc.org/pdf/PartneringwithPatientsandFamilies.pdf; National Initiative for Children's Healthcare Quality, Powerful Partnerships: A Handbook for Families and Providers Working Together to Improve Care (2011), see: http://www.nichq.org/documents/powerful%20partnerships.pdf

11. Berwick DM., Nolan TW, Whittington J. The triple aim: Care, health and cost. Health Affairs (2008); 27(3):759-769

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