The Medical Home Model: What Is It And How Do Social Workers Fit In?

Background

The “medical home” concept dates to the late 1960s and has, until recently, been confined largely to the pediatric community. However, in the health reform era, the concept is being embraced as a model of health care delivery that is comprehensive and cost-efficient, particularly for people with complex health conditions. Medical homes are growing rapidly, fueled by interest from both the public and private sectors. The hallmark of the medical home is integrated, multi-disciplinary care that meets a patient’s physical and behavioral health needs. The Affordable Care Act of 2010 advances a systems-level movement toward accountable care organizations (ACOs)—a health care delivery model designed to promote shared accountability for improving patient care and containing costs for a defined population. Social workers are well positioned to participate in these health delivery models—and have demonstrated their value in many of the medical home demonstration projects currently underway throughout the nation.

What is a medical home?

At its most fundamental, a medical home suggests an ongoing relationship between an individual and his or her primary care team. A medical home provides care that is patient-centered, team-based, comprehensive and coordinated. The Agency for Healthcare Research and Quality (AHRQ) suggests that a medical home is not just a place, but a model for organizing primary care that meets the large majority of a patient’s physical and mental health needs, including preventive and wellness, acute and chronic care (AHRQ, 2010). A medical home provides care through an interdisciplinary team, composed of physicians, advance practice nurses, physician assistants, nurses, social workers, and pharmacists. Some medical homes will employ diverse teams directly, others will build school teams, linking themselves and their patients to providers and services in their communities. Medical homes vary in size from small physician practices to medium-scale non-profit health centers and from clinic to large scale (e.g., non-profit health systems and the Department of Veterans Affairs).
An estimated 65 million expansion of the Barriers to... per capita than any other U.S. spends more on specialist doctors and specialist... (Tataw, 2010). However, current health policy coverage and enrollment. The interdisciplinary team approach offers opportunities to improve care and lower costs, especially for patients with depression, physical disabilities, and other conditions that have proven difficult to treat in primary care settings. (Commonwealth Fund, 2010). Coordinated care also frees up physician time—responsibilities of the other staff members—so that a practice environment where all staff care at the highest level their license or certification allows. The University of Oklahoma School of Medicine—OU School of Community Medicine—enrolls... peers not receiving this intervention (Golden, 2011). In addition, older adults schedule and attend their follow-up medical appointments more frequently not receiving this intervention (Golden, 2011). Enhanced Discharge Planning Program—Kans University Medical Centers Older Adult Programs and Care Management Department have created the social work-based Enhanced Discharge Planning Program (EDPP). In the intervention, social workers phone patients and caregivers after discharge to ensure they are receiving the services included in their discharge plan. Social workers help patients social administration, discharge planning with primary care providers, and contact patients and caregivers to communicate barriers (KDA, 2010). Data from the project show statistically significant increases in service utilization, self-management, access, and improved communication with their physician postdischarge. In addition, older adults schedule and attend their follow-up medical appointments more frequently not receiving this intervention (Golden, 2011). Care coordination is central to the shift in orientation away from a focus on episodic acute care to a focus on managing illness and facilitating preventive self-care, especially for those living with chronic health conditions.

Unique Features of The Medical Home Model

- Use of Meaningful Performance measures: Current medical home demonstration projects— as well as payment models for ACOs—are using key performance measures to gauge their effectiveness. These include:
  - Reducing 30-day hospital readmissions.
  - Delays in treatment time.
  - Avoiding unnecessary hospital stays.
  - Increasing access to primary care.
  - Improving patient satisfaction.
  - Decreasing hospital disparities.

Daily evidence suggests that medical homes have the potential to improve quality and reduce costs. Among schedulable populations, medical home programs are proving important in access to primary care and in reducing costs and avoidable emergency department visits (Kussatich, 2009). Demonstration projects involving social workers (see below) are also showing positive trends on many of these measures.

- Emphasis on Care Coordination and Interdisciplinary Teams

As essential features of the patient-centered medical home care coordination, AHRQ defines care coordination as “the deliberate organization of patient care activities between two or more practitioners (including the patient) involved in a patient care to facilitate the appropriate delivery of health care services” (AHRQ 2010). Care coordination is central to the shift in orientation away from a focus on episodic acute care to a focus on managing illness and facilitating preventive self-care, especially for those living with chronic health conditions.

What do social workers offer to the medical home team?

Social workers can provide valuable functions not a medical home team, including:

- Comprehensive assessment and case management, especially for high-priority patients
- Care coordination/patient navigation
- Health promotion and disease self-management education
- Functional care
- Patient and family support
- Links to community services
- Psychotherapy/Crisis intervention
- Personal care planning and referral navigation

The inclusion of social workers on the team ensures an awareness of the socioeconomic factors that impact patient well-being—namely, environmental and psychosocial needs. Moreover, the social work profession’s ecological framework promotes interaction on both individual and systemic levels. As a result, patients and caregivers can better support and more easily navigate the complexities of the health care system with the social worker’s guidance (Golden, 2011). The presence of a social worker who can address a patient’s social needs also allows other members of the interdisciplinary medical home team to focus on their specific areas of expertise.

Social work involvement in medical home initiatives

Geriatric Resources for Assessment and Discharge Planning Program (EDPP). In this intervention, social workers phone patients and caregivers after discharge to ensure they are receiving the services included in their discharge plan. Social workers help patients social administration, discharge planning with primary care providers, and contact patients and caregivers to communicate barriers (KDA, 2010). Data from the project show statistically significant increases in service utilization, self-management, access, and improved communication with their physician postdischarge. In addition, older adults schedule and attend their follow-up medical appointments more frequently not receiving this intervention (Golden, 2011).
Unique Features of The Medical Home Model

- Use of Meaningful Performance measures: Current medical home demonstration projects – as well as payment models for ACOs – are using key-performance measures to gauge their effectiveness. These include: Reducing 30-day hospital readmissions; Delaying permanent nursing home placement; Reducing avoidable emergency room visits; Increasing access to primary care; Improving patient satisfaction; Decreasing health disparities.

Early evidence suggests that medical homes have the potential to improve quality and reduce costs. Among vulnerable populations, medical home programs are showing improved access to primary care and reductions in avoidable emergency department visits (Koresh, 2008). Demonstration projects involving social workers (see below) are also showing positive trends in many of these measures.

- Emphasis on Care Coordination and Interdisciplinary Teams

As essential features of the patient-centered medical home, care coordination and interdisciplinary care are crucial. ARQS defines care coordination as “the deliberate organization of patient care activities between two or more practitioners (including the patient) involved in a patient’s care to facilitate the appropriate delivery of healthcare services” (ARQS 2010). Care coordination is central to the shift in orientation away from episodic acute care to a focus on managing illness and facilitating preventive self-care, especially for those living with chronic health conditions.

Care coordination is central to the shift in orientation away from episodic acute care to a focus on managing illness and facilitating preventive self-care, especially for those living with chronic health conditions (NCCBH, 2009). Within a medical home, teams of health care professionals from different disciplines and practice areas share responsibility for managing key components of patient care.

The interdisciplinary team approach offers opportunities to improve care and lower costs, especially for patients with depression, physical disabilities, and other conditions that have proven difficult to treat in primary care settings. (Commonwealth Fund, 2010). Funded care also frees up physician time—responsibilities of all other staff members—and promotes an environment where all staff can practice at the highest level their license or certification allows.

- Integration of Behavioral Health into Primary Care

Many health problems first emerge in primary care settings, for many vulnerable populations, primary care is often the only source of mental health treatment. Rates of mental health problems are significantly higher for patients with chronic health conditions, including diabetes, heart conditions, asthma, and mental health and mental health conditions among poor women and children (NCCBH, 2009). Although not consistently integrated into all medical homes, behavioral health-care coordination is increasingly recognized as an important component of the medical home model (Blais, 2011). What do social workers offer to the medical home team?

Social workers can provide invaluable functions in a medical home team, including:

- Care coordination and case management, especially for high-risk patients
- Care coordination and patient navigation
- Health promotion and disease self-management education
- Functional care
- Patient and family support
- Liaison to community services
- Psychological/Clinical intervenors
- Care planning/family of the patient

The inclusion of social workers on the team ensures an awareness of the nonmedical factors that impact patient well-being—namely, environmental and psychological needs. Moreover, the social work profession’s ecological framework promotes intervention on both individual and systemic levels. As such, patients and caregivers can be better supported and more able to understand the consequences of the health care system with the social worker’s presence (Gibler, 2011). The presence of a social worker who can address a patient’s mental health concerns also allows other members of the interdisciplinary health care team to focus on their specific areas of expertise.

Social work involvement in medical home initiatives

ComerCare: Common Care Alliance (CCA)
The GRACE (Genetic Resources for Assessment and Counseling) program allows medical home project members to offer practitioners/social work case management teams in 25 community-based medical practices. These teams include social workers, who are typically responsible for the ambulatory care needs of patients assigned to them. Teams often receive direct and indirect support from GRACE administrators, working in close collaboration with interprofessional teams. The inclusion of social workers in this model allows for increased access to care, as well as improved screening for mental and drug and alcohol abuse.

CuraCare: Care Alliance (CCA)
ComerCare is a Boston-based HMO serving seniors and medically fragile individuals in Massachusetts. The CCA’s care management function is delivered by CuraCare’s Enhanced Discharge Planning Program, which centralizes care management functions among community-oriented care teams to improve care coordination and reduce avoidable hospitalizations. CuraCare’s care management function is delivered by CuraCare’s Enhanced Discharge Planning Program, which centralizes care management functions among community-oriented care teams to improve care coordination and reduce avoidable hospitalizations.
Key services provided by a patient-centered medical home

- Preventive screening, health promotion
- Acute primary care
- Coordination of care services and specialty care
- Management of chronic health conditions
- Advanced health care
- Palliative care or support

Medicare C-HIT2, compared to 3.6 days annually eligible patients enrolled in the Medicare Health Insurance program. Also, the percentage of nursing-home-refurbished patients significantly increased to the nursing home per year is 8.5 percent, compared with the overall Massachusetts rate of 12 percent (Commonwealth Fund, 2010).

General Health System: Health Navigator Self Management Support Model

General Health System, which was to 36,000 covered lives, employs health navigators to work with primary care providers on chronic disease self-management. Navigators have varied backgrounds, including former patients, health educators, nurses, and social workers. The health system has seen improvement in management of diabetes, chronic pain, and depression among patients assigned to navigators.

Prevention Health Education and Medical Home Project: Alzheimer’s (PHEMHP)

PHEMHP is a program to address both the financial and non-financial aspects of quality care and health status for low-income urban children and families in South Central Los Angeles. Through educational and care management strategies, the program is designed to reduce the levels of health service utilization and improve preventive health behaviors and disease self-management, with the ultimate goal of improving the health status of all children in a medical home (Tavares, 2013).

Infectious Model

IMPACT (Improving Mood – Promoting Access to Collaborative Treatment for Late-Life Depression) is a randomized approach to treating depression in a primary care setting. IMPACT is a collaborative care model, in which the individual’s primary care physician works with a care manager (a nurse, social worker, or psychologist) to develop and implement a treatment plan. The care manager and primary care provider consult with a psychiatrist to change the treatment plan. If the individual’s depression does not improve, IMPACT would be continued.

PHEMHP data have shown improvements in depression management, physical functioning, and pain status for participants (Tavares, 2009).

What are Social workers do to Promote Medical Homes?

- Work with VASHOB to develop care coordination for veterans who have been involved in mental health treatment programs. Currently, 27 partial-benefit VASHOB projects are underway in 18 states. The program website includes a tool of websites on advancing the medical home model. (www.va.gov/health/default.asp)

References


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What can Social workers do to Promote Medical Homes?

- Work with VASHOB to develop care coordination for veterans who have been involved in mental health treatment programs. Currently, 27 partial-benefit VASHOB projects are underway in 18 states. The program website includes a tool of websites on advancing the medical home model. (www.va.gov/health/default.asp)
The IMPACT Model: IMPACT (Improving Mood – Promoting Access to Collaborative Treatment for Late-Life Depression) is a research-based approach to treating depression in primary care settings. The IMPACT Model is designed to improve the care of patients with depression in primary care settings, to reduce the burden of depression on patients, and to improve the quality of care provided to these patients. The IMPACT Model is based on the principles of the collaborative care model, in which the primary care provider works closely with a care manager (usually a nurse, social worker, or psychologist), to develop and implement a treatment plan for each patient. The care manager helps the primary care provider to identify patients who may benefit from additional support, and to monitor their progress over time. The IMPACT Model has been shown to be effective in improving the care of patients with depression, and to be cost-effective compared to traditional treatment approaches.

IMPROVE: IMPROVE (Integrating Mental Health Services into Primary Care) is a comprehensive approach to treating depression in primary care settings. IMPROVE is a collaborative care model, in which the individual primary care provider works with a care manager to develop and implement a treatment plan for each patient. The care manager and primary care provider work together to change the treatment plan if the individual’s depression does not improve. IMPROVE has been shown to be effective in improving the care of patients with depression, and to be cost-effective compared to traditional treatment approaches.

The AHRQ Patient-Centered Medical Home Resource Center: The Certificate Program in Primary Care Behavioral Health is a training program for behavioral health professionals seeking to practice in primary care settings. The program is approved by the American Nurses Credentialing Center (ANCC) and the American Academy of Family Physicians (AAFP) as a Collaborative Behavioral Health Practitioner. The program is designed to prepare behavioral health professionals for the complex demands of primary care practice, and to ensure that patients receive high-quality care.

References:
- Coordinating Patient Care. AHRQ Publication No. 11-M005-EF. Rockville, MD.
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