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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 home programs 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 manifestation of the medical home—the "accountable care organization" (ACO)—a health care delivery model intended to promote shared accountability for improving patient care and controlling 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 demonstrations projects currently underway throughout the nation.

What is a medical home?

At its most fundamental, a medical home suggests an on-going 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 care needs, including prevention and wellness, acute and chronic care (AHRQ, 2010). A medical home provides care through an interdisciplinary team, composed of physicians, advanced practice nurses, physician assistants, nurses, social workers, and pharmacists. Some medical homes will employ diverse teams directly; others will build virtual teams, linking themselves and their patients to providers and services in their communities. Medical homes vary in size from small (physician practices) to mid-size (safety net providers such federally qualified health clinics and free clinics) to large scale (e.g., non-profit health systems and the Department of Veterans Affairs).

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Barriers to expansion of the medical home model

- An estimated 65 million Americans live in officially designated primary care shortage areas. Although the U.S. spends more on specialist care and has more specialists per capita than any other leading industrialized country, the number of medical students entering internal and family medicine residencies is steadily declining.
- Coordination between primary care physicians, specialists, and hospitals is often lacking; each of these health care providers is often unaware of the others' treatment plans.
- Current fee-for-service and procedure-based payment systems that dominate much of U.S. health care benefit doctors and specialist physicians (Project HOPE, 2010).
- For vulnerable populations, health promotion and disease self-management education are as important as medical coverage and enrollment. However, current health policy allows no reimbursement mechanism for these services (Tataw, 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 preventative 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 re-admissions
- 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 improvement in access to primary care and reductions in avoidable emergency department utilization (Grumbach, 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

An essential feature of the patient-centered medical home is care coordination. AHRQ defines care coordination as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's 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 preventative 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). Team-based care also frees up physician time—as responsibilities shift to other staff members—and promotes a work environment where all staff can practice at the highest level their licensure or certification allows.

■ Integration of Behavioral Health into Primary Care

Most mental 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 certain chronic conditions (e.g., diabetes, heart conditions, asthma). Failure to treat both physical and mental health conditions yields poorer outcomes and higher costs. (NCCBH, 2009). Although not consistently integrated into all medical homes, behavioral health—through co-location or referral protocols—remains an important component of the medical home model (Blount, 2011).

What do social workers offer to the medical home team?

Social workers can provide valuable functions on a medical home team, including:

- comprehensive assessment and case management, especially for high-risk patients
- care coordination/patient navigation
- health promotion and disease self-management education
- transitional care
- patient and family support
- linkages to community services
- psychotherapy/clinical intervention
- advance care planning/end of life assistance

The inclusion of social workers on the team ensures an awareness of the non-medical factors that impact patient well-being – namely, environmental and psychosocial needs. Moreover, the social work profession's ecological framework promotes intervention on both individual and systemic levels. As a result, patients and caregivers are better supported and more able to navigate the complexities of the health care system with the social worker's assistance (Golden, 2011). The presence of a social worker who can address a patient's non-medical 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

Geriatric Resources for Assessment and Care of Elders

The GRACE (Geriatric Resources for Assessment and Care of Elders) medical home project includes a nurse practitioner/social worker care coordination team, which works closely with primary care physicians and a geriatrician. The program, situated at an urban system of community clinics affiliated with the Indiana University School of Medicine, enrolls low-income seniors with multiple diagnoses. Data from the project show decreased use of the emergency department and lower hospitalization rates among seniors receiving the GRACE intervention, compared with those in control groups (Counsell, et.al., 2007).

Enhanced Discharge Planning Program

Rush University Medical Center's Older Adult Programs and Case Management Department have created the social work-based Enhanced Discharge Planning Program (EDPP). In this intervention, social workers phone patients and caregivers after discharge to ensure they are receiving the services detailed in their discharge plan. Social workers help patients avoid adverse events, encourage follow-up with primary care providers, and connect patients and caregivers to community-based resources (AHA, 2010). Data from the project show statistically significant increases in seniors' understanding of their medications, decreased stress over managing their health care needs, and improved communication with their physicians post-discharge. In addition, older adults schedule and attend their follow-up medical appointments more than peers not receiving this intervention (Golden, 2011)

OU School of Community Medicine—Patient-Centered Medical Home Project

The University of Oklahoma School of Community Medicine is shaping its teaching clinics on the medical home model, to provide patients with better access to primary and specialty care, increased access to medical advice, and more efficient and effective treatment for chronic conditions. New services to achieve this goal include placing social work staff in care coordination roles, forming integrated care teams and improving screening for mental and behavioral health concerns (PCPCC, 2010).

Commonwealth Care Alliance (CCA)

CCA - a Boston-based HMO serving seniors and medically fragile individuals on Medicaid, uses nurse practitioner-lead teams in 25 community-based medical practices. These teams, which include social workers, are largely responsible for the ambulatory care needs of patients assigned to each practice. Teams provide intake and assessment, on-going care coordination and in-home assistance with activities of daily living. The physicians on the team focus primarily on inpatient care. CCA's data are promising. The number of hospital days per year per CCA member who is dually eligible for Medicare and

The Duality of Social Work Practice in the VA Medical Home Model

Two distinct social work practice roles can be found within the VA medical home system: **Mental Health Clinicians and Medical Social Workers.**

Mental health social workers provide individual, group, and family therapy; drug and alcohol counseling; and assistance to veterans and their families in adjustment to illness or disability, and terminal illness.

Medical social workers provide case management functions such as linking veterans and their family members with resources within the VA system and in their community; assisting veterans with health care advance directives; and providing patient education (US Dept of Veterans Affairs, 2011)

Key services provided by a patient-centered medical home

- Preventive screening/health education
- Acute primary care
- Coordination of diagnostic services and specialty care
- Management of chronic health conditions
- Behavioral health care
- End of life care (source: Commonwealth Fund)

Medicaid is 2.0, compared to 3.6 days per dually eligible patient enrolled in the Medicare fee-for-service program. Also, the percentage of nursing home–certifiable patients permanently placed in the nursing home per year is 8.5 percent, compared with the overall Massachusetts rate of 12 percent (Commonwealth Fund, 2010).

Genesys Health System: Health Navigator Self Management Support Model

Genesys, a large, integrated health system in Michigan with 59,000 covered lives, employs health navigators to work with primary care patients on chronic disease self management. Navigators have varied backgrounds, including social workers, health educators, dieticians, and nurses. The health system has seen improvement in management of diabetes, chronic pain, and depression among patients assigned to navigators.

Preventive Health Education and Medical Home Project for children (PHEMHP)

PHEMHP is a program to address both the financial and nonfinancial aspects of health care access and health status for low-income urban children and families in South Central Los Angeles. Through educational and case management strategies, the program is designed to reduce low levels of health services utilization and improve preventive health techniques and disease self-management, with the ultimate goal of attaching each child to a medical home (Tataw, 2010).

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. IMPACT is a collaborative care model, in which the individual's primary care physician works with a care manager (usually 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 Model data have shown improvements in depression management, physical functioning, and pain status for participants (NCCBH, 2009).

What can Social workers do to Promote Medical Homes?

- Work with NASW state chapters to ensure social work involvement in state-level Affordable Care Act medical home demonstration projects, especially medical homes for Medicare/Medicaid enrollees with chronic conditions
- Insist that medical home projects include prevention and treatment of mental illness and substance use disorders, along with chronic disease management
- Partner with key stakeholders – state Medicaid and Medicare programs, provider and payor organizations, patient advocacy organizations and other groups – on medical home implementation efforts
- Provide expertise on the unique needs of vulnerable populations in the development and implementation of medical home demonstration programs
- Engage families and consumers in the work of promoting and advancing the medical home concept.

Resources

The AHRQ Patient Centered Medical Home Resource Center. This web site provides policymakers and researchers with access to evidence-based resources about the medical home model. www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483

The Certificate Program in Primary Care Behavioral Health is a training program for behavioral health professionals seeking to practice in primary care settings. This training is particularly targeted to prepare behavioral health professionals for the patient centered medical home model. This program is approved for CEs through NASW. http://umassmed.edu/fmch/pcbh/welcome.aspx

National Center for Medical Home Implementation, sponsored by the American Academy of Pediatrics, is a web-based resource center for health professionals and families interested in medical home information for children and adolescents. http://medicalhomeinfo.org/

Patient-Centered Primary Care Collaborative (PCPCC). The mission of the PCPCC is to strengthen the primary care delivery system in the US and to advance the patient centered medical home model. Sponsored by provider groups, large employers and insurance organizations, the PCPCC plays an active

role as a convener and supporter of medical home demonstration projects and pilot programs. Currently, 27 multi-stakeholder PCPCC projects are underway in 18 states. The program website includes a host of materials on advancing the medical home model. www.pcpcc.net/

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