



Medical Homes in the Safety Net: Spotlight on California's Public Hospital Systems

Introduction

The concept of medical homes has garnered a lot of attention in recent months, particularly in national health care reform and state Medicaid waiver discussions.ⁱ Amidst this public policy discourse, California's public hospital systems have developed first-hand knowledge of medical homes based on their experience in providing them for safety net patients. As part of system-wide efforts to offer more coordinated, integrated and patient-centered care, California's public hospitals have redesigned scores of their primary care clinics to serve as medical homes for tens of thousands of low-income Californians.

In fact, public hospital medical homes are specially geared to meet the needs of very diverse patient populations that suffer from multiple health conditions.ⁱⁱ Public hospitals have found that for their many patients who have complex, chronic conditions, the need for a medical home is particularly important. The medical home serves as a "home base" where patients receive routine primary and preventive care and have their health care services coordinated. Furthermore, public hospital medical homes connect patients to a wide range of social and related health services. As a result, patients may see their health improve and some illnesses prevented, rely less on costly emergency room visits, and incur fewer avoidable hospital stays. At the system level,

health care costs can be better managed and waste and duplication can be reduced.

This brief offers:

- Core components for defining a medical home based on the experience of California's public hospital systems in serving vulnerable populations;
- Examples of public hospital medical homes that deliver care to safety net patients; and
- A look ahead to California's next Medicaid waiver as a vehicle for the critical investment needed to improve the delivery of health care.

Leaders In Innovative, Effective Outpatient Care

California's public hospitals are the core of the state's health care safety net, delivering care to all who need it. As comprehensive systems of care, California's public hospitals serve a complex and diverse patient population. Though just six percent of all California hospitals statewide, public hospitals serve 2.5 million Californians each year and provide nearly half of all hospital care to the state's 6.7 million uninsured residents. Approximately 70 percent of our patient population has either Medi-Cal coverage or no insurance. More than half of all patients primarily speak a language other than English, and

ⁱThe Section 1115 Medicaid waiver is an agreement between a state and the federal government that waives certain Medicaid program requirements to allow the state to demonstrate innovations. Many states operate various Medicaid waivers, and California has operated under Medicaid waivers for many years. One of California's Medicaid waivers is the source of core funding for California's public hospitals.

ⁱⁱWe use the term "medical home" in this brief to align with other nationally recognized organizations that use the same terminology. Public hospitals recognize the need for a medical home to coordinate the entire array of a patient's needs, including behavioral health care needs; however, all services needed by the patient do not necessarily have to be provided by the medical home itself.

California's public hospitals are national leaders in providing qualified health care interpretation in virtually every language to facilitate communication between the provider and patient.

Public hospital outpatient clinics are improving primary care access, quality and efficiency through multiple pilots and programs, many of them launched by the California Health Care Safety Net Institute.ⁱⁱⁱ For example, they have

"It's really helped: I've changed my diet, I've changed my eating, I've changed my lifestyle, I've changed my thoughts..."

I am very, very grateful. Without you guys, there'd be a lot of us that would be just lost in the dark."

- Ardes Gardner, of the care he receives from Newark Health Center's providers

redesigned clinic visits around the patient, thereby significantly reducing patient wait times by more than 40 percent on average. About 80 percent of the more than 100 public hospital primary care clinics across the state have implemented best practices to improve care for the chronically ill, including tracking the health of patients with or at risk for chronic diseases and conducting more checks and screenings to prevent infections and the worsening of health conditions. Furthermore, public hospitals continue to integrate information technology improvements – for medical records, prescriptions, referrals and patient monitoring – to better coordinate care and increase patient access to specialty services.

All of these important innovations build on public hospitals' efforts to provide effective medical homes

for patients. Rather than delivering only episodic treatment, public hospitals are implementing medical homes that offer long-term, whole-person health care that is planned and coordinated by a reliable care team. However, replicating these medical homes across all public hospital systems requires significant investment.

The Coverage Initiatives

California's Health Care Coverage Initiatives (CIs), which were created in 2007 as part of the current Medicaid waiver, have expanded health care coverage and provided medical homes. Of the 10 CI programs, eight are in counties where public hospitals are at the center of the CI provider networks. All CI enrollees are provided with medical homes for routine primary, preventive and chronic care.

Coverage Initiatives' Initial Results

In less than three years, the CIs have:

- Expanded coverage to more than 100,000 low-income adults
- Increased access to care by providing a medical home for every enrollee
- Improved the use of efficient processes, such as redesigned patient visits
- Provided chronic disease management and case management to enrollees

Core Components Of A Medical Home

Many definitions of medical homes have been put forth by various national and state policy organizations. California's public hospitals have found that no single existing definition truly captures what effective medical homes should look like on the ground for safety net patients. Building on current definitions, and adding public hospitals' expertise

ⁱⁱⁱThe California Health Care Safety Net Institute (SNI) is the quality improvement affiliate of the California Association of Public Hospitals and Health Systems (CAPH). SNI designs and directs programs to accelerate the spread of innovative practices among public hospitals, public clinics and beyond. Please see <http://safetynetinstitute.org> for more information.

in providing system-based care to a diverse patient population, CAPH offers eight core components that define a medical home. Public hospital systems' medical homes have not yet achieved every element of this definition across the board. Rather, we offer the following components as a proposed standard or benchmark to which we believe all outpatient clinics should aspire:

1. *Care is Tailored to the Patient's Health Needs.*

Health care services are proactive, planned and grounded in evidence-based medicine. A medical home provider team first assesses the current and

anticipated health care needs of the patient. Based on this assessment, the patient is assigned to a specific medical home team. Patients receive medical home interventions that align with their individual health needs. Care must be delivered in a culturally and linguistically competent manner. Providers treat patients with cultural humility and tailor patient care to meet whole-person needs.

2. *A Team of Providers is Responsible for the Patient's Care.*

Based on the patient's health assessment, the most appropriate team takes responsibility for the patient's

Highlighting Key Elements of Public Hospital Medical Homes across the State

All public hospital medical homes offer a common set of coordinated services and share the same medical home goals. Of these many shared elements, below are some highlighted focal points:

- Ocean Park clinic in San Francisco focuses on *integrating behavioral and physical health*.
- Eastmont Wellness Center in Oakland monitors patients' health through disease registries to provide *proactive care for patients with chronic conditions*.
- Richmond Health Center *connects patients with community resources* such as transportation and housing.
- Harbor-UCLA Family Health Center in Los Angeles utilizes health education assistants – including *promotoras* – to *promote patient wellness and help patients set achievable, life-changing health goals*.
- Alisal Health Center in Salinas focuses on *disease prevention* and has been integrated with other Monterey County primary care clinics to coordinate services for residents.
- Riverside County Regional Medical Center clinics have achieved *breakthrough successes in testing diabetic patients' blood sugar using diabetes registries* and in prescribing a trio of *preventive medications proven to reduce the risk of heart attacks and strokes*.
- University of California Davis Medical Center clinics utilize *electronic medical records* to better track patients, coordinate their care and facilitate communication among providers.
- McKee Family Health Center in San Bernardino has *redesigned its patient visits to be more efficient and patient centered*, significantly reducing patient wait-times.
- San Joaquin General Hospital clinics provide *health care interpretation services* through remote video access in virtually every language.
- San Mateo Medical Center's Innovative Care Clinic pharmacists *review and reconcile patient medication lists* to improve patient safety.
- Santa Paula Medical Clinic targets children and their families to provide education on weight, nutrition and fitness as part of *childhood obesity and diabetes prevention*.

Public Hospital Medical Home: Example in Silicon Valley

The Santa Clara Valley Health Center at Silver Creek shows how patient-centered, coordinated care through a medical home can increase access and improve the health of patients. This primary care clinic was redesigned to focus on improving the patient's experience, quality of care and access to care; empowering and preparing patients to manage their health; and reducing cost growth.

The clinic is assigned a panel of patients, and a medical team becomes responsible for all aspects of its patients' care. If a patient seeks care elsewhere, it is the team's job to find out why and understand if such care could be better provided in the primary care setting. The team monitors its patients' health through an automated registry that allows it to track patients' progress and identify populations of patients for intervention. The team has implemented electronic medical records to improve care coordination and assist with reconciling medication lists to help reduce medical errors. The team also communicates with patients to make sure they understand their medication regimens.

Valley Health Center at Silver Creek Initial Results

As a result of redesigning Valley Health Center as a medical home, the clinic has:

- Increased patient access to care by opening additional touch points for patient interaction, including improved phone access, group visits, health education opportunities and visits with non-physician clinical staff such as psychologists, health educators, disease care managers and nursing staff
- Utilized a follow-up process to better manage clinic patients who use urgent care or the emergency department, or are admitted to the hospital
- Implemented programs to increase patients' abilities to manage their chronic disease
- Enhanced programs to identify and address patients' preventive care needs, including flu vaccinations and mammogram screening

health care. Patients and their caregivers are at the center of the care team. The relationship between the care team and the patient is one of healing, familiarity, trust and respect. The care team is accountable for providing much of the patient's core health care needs as well as for coordinating the patient's full range of health needs. The care team likely includes at least one physician, additional clinical staff, and/or a physician-extender, such as a nurse or physician's assistant. All team members work to their full scope of practice, so not every encounter needs to be with a physician. In this way, the patient receives the most appropriate

level of care, which tends to be more accessible, affordable and efficient.

3. Patients Are Engaged in Their Own Planned, Whole-Person Care.

A medical home model restructures the patient-provider relationship. Providers are proactive in planning and coordinating the continuum of the patient's care. Patients and, when appropriate, their families, are fully engaged in their health care and collaborate on individualized goal-setting. Chronically ill patients are coached on self-managing

their conditions, which includes identifying how to stay healthy in a way that fits with their daily lives. Some examples of tools that help empower patients in managing their illness include culturally and linguistically appropriate nutritional counseling, educational materials, referrals to community resources and support groups.

4. Care is Continuous, Comprehensive and Coordinated.

The care team is responsible for coordinating the patient's care through all stages of life and across all elements of the complex health care system, including primary and preventive services, chronic care, behavioral health, specialty services, acute care and end-of-life care. The care team arranges for referrals to other qualified professionals, and follows up after the patient has

utilized other services. When needed, appropriate care and case management as well as access to community resources are provided.

5. Care is Driven by Measures and Supported by Technology.

A medical home uses specific standard clinical and service measures to drive quality improvement. A medical home's care coordination efforts are supported by clinical decision support tools, including registries. Care through a medical home can be further improved through the use of electronic medical records, including e-referrals and e-prescribing.

6. The Patient has Access to Care.

In order to make sure that patients receive timely access to care – before their medical situation be-

Public Hospital Medical Home: Example in Bakersfield

The Kern Medical Center Health Plan (KMCHP) is an integration of community clinics within the Kern County Healthcare Network that represents Kern County's Coverage Initiative (CI) program. The plan's goal is to develop a sustainable health care system with neighborhood access to primary care, enhanced access to specialty and diagnostic care, and the coordination of primary care with inpatient and outpatient specialty and diagnostic services. The hub of KMCHP's coordinated care is the medical home.

KMCHP patients with complex needs and a history of high utilization of health care services may be provided with care managers. The care manager acts as the patient's main point of contact and makes sure the patient receives regular primary and preventive services, and chronic care when needed. If the patient's health changes suddenly, the patient can call the care manager, who will provide guidance and contact the patient's health care team, if needed. Consistent with other public hospital medical homes, KMCHP patients are assisted in scheduling appointments, understanding medications and physician advice, navigating specialty and other needed services and community resources, setting goals to make their lifestyles healthier, and managing paperwork.

Kern Medical Center Health Plan Initial Results

As a result of redesigning their clinics to serve as medical homes, KMCHP has:

- Provided more than 6,300 patients with a medical home in just two years
- Reduced costs per patient by more than \$1,200 from the first to the second year
- Reduced emergency department visits by 60 percent among CI enrollees
- Reduced inpatient hospital days by 40 percent among CI enrollees

comes more serious or they need to seek emergency services – a medical home provides:

- Open access scheduling (such as walk-in or same- or next-day appointments)
- Extended hours
- Expanded communication options for patients, such as a 24/7 nurse advice line or other after-hours access points
- Urgent care affiliation

7. The Patient and the Care Team Engage in Open and Effective Communication.

Patients can communicate with their care team when they need to, when and how it is convenient for the patient, and in a manner that is comfortable for the patient. As such, interactions should allow for office visits, phone calls and e-mails, depending on the patient's needs and circumstances. Also, the medical home provides qualified health care interpretation in the patient's preferred language, as well as translated health care and educational materials. The care team communicates with cultural respect and engages the patient as part of the care team. As a result, communication is two-way and based on an ongoing, open relationship.

8. Reimbursement Should Adequately Reflect the Cost and Value of Medical Homes.

Many of the above medical home components describe non-reimbursable services, and thus, medical homes are providing improved care despite the lack of needed financial support. Reimbursement should adequately value the extent of services provided by the medical home, such as clinical services, coordination of care, care management, health information systems, counseling, education, group visits, multiple visits in one day and behavioral health services.

Looking To The Next Medicaid Waiver

Given their limited resources, California's public hospitals have worked diligently to maximize exist-

ing resources, streamline and coordinate services, and contain costs in their efforts to provide patients with medical homes. However, public hospitals cannot fully implement effective medical homes across their systems under the current Medicaid waiver's payment structures and funding limitations.

Significant resources and investment are required to systemically improve outpatient care and provide medical homes for safety net patients. Implementing medical homes requires considerable start-up costs, especially for technology and infrastructure improvements. Based on their on-the-ground experience in providing medical homes within the safety net, public hospitals appreciate the multiple elements of integration needed to provide coordinated care – technology, specialty care access, case management and population management, just to name a few. Forward-thinking financial and policy support is needed in order to achieve this goal.

The next Section 1115 Medicaid waiver must provide the investment needed to build upon the positive reforms in the public hospital safety net through the further development of medical homes and coordinated care. California's public hospitals have had significant successes in piloting medical homes, and are eager to spread this model to hundreds of thousands more patients. Furthermore, they are specially structured to demonstrate the medical home model because they are health systems that provide a coordinated approach to care vis-à-vis integrated primary and specialty care services and system-wide tools and resources. In addition, public hospitals provide the non-federal share to draw down the federal waiver dollars, so they are able to capture additional federal funding to support this necessary investment. Such an endeavor would bring tremendous health benefits to Californians, advance efforts to contain costs in the state's health care system, and prepare the public hospital safety net for a reformed health care system.