National Rural Health Association Policy Position

Health Home

The Patient-Centered Health Home (PC-HH) is an approach to providing comprehensive primary care services for children, youth, and adults. The PC-HH is a health care encounter that facilitates partnerships among individual patients, their personal providers, and when appropriate the patient's family and significant others.

The NRHA, representing approximately 18,000 members has developed the following principles to describe the characteristics of the PC-HH.

Principles

Personal Health Provider—each patient has an ongoing relationship with a licensed practitioner (LICENSED PRACTITIONER) trained to provide first contact, continuous and comprehensive care.

Licensed Practitioner—the personal licensed practitioner leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation-the personal licensed practitioner is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the health home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership among providers, patients, and the patient's family and/or significant others.
- Evidence-based health care and clinical decision-making support tools guide decision-making.
- Licensed practitioners in the practice accept accountability for continuous performance measurement and improvement.
- Patients, their families, and/or significant others actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Health Homes go through a voluntary recognition process by an appropriate entity to demonstrate that they have the capabilities to provide patient centered services consistent with the health home model.
- Patients and families participate in quality improvement activities.

Enhanced access to care is available through systems such as open scheduling, expended hours, in-home visits, and new options for communication among patients, their personal Licensed Independent Practitioner, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered health home. The

payment structure should be based on the following framework:

- It should reflect the value of Licensed Practitioners and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication assess such as secure e-mail and telephone consultation;
- It should recognize the value of Licensed Practitioners work associated with remote monitoring of clinical data using appropriate technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits.)
- It should recognized case mix differences in the patient population being treated within the practice.
- It should allow Licensed Practitioners to share in savings from reduced hospitalizations associated with Licensed Practitioners-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

The National Rural Health Association, the largest organizations representing individuals who live and work, and work for quality of life in rural America, building upon the thoughtful work of the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and the American Osteopathic Association (AOA), acknowledges the concepts held within their document, the "Joint Principles of the Patient-Centered Medical Home."

Policy adopted October 2008.

Government Affairs Office
1108 K Street NW, 2nd Floor
Washington, DC 20005
(202) 639-0550

You can access this document online at http://www.RuralHealthWeb.org.