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BMoC BOYS AND
YOUNG MEN
OF COLOR
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THE HEALTH HOME: AN APPROACH FOR IMPROVING HEALTH OUTCOMES FOR BOYS AND YOUNG MEN OF COLOR

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INTRODUCTION

Most studies of health outcome inequality in the United States show striking health disparities based on race and ethnicity, even when controlling for socioeconomic factors.¹ Digging further into the data, the disparities become more pronounced when the health outcomes of boys and young men of color (BMoC) are compared to those of other groups. These disparities, of course, do not emerge from a vacuum—it is well documented that social determinants play a central role in shaping health outcomes.² Within the larger problem of health outcome disparity, this brief will focus on ways the healthcare delivery system can address the health access realities that BMoC face today and in the near future. Specifically, this brief explores the health home model, which aptly fits the changing landscape of the healthcare system and provides the flexibility necessary to increase healthcare access for boys and young men of color.

This brief first provides a general overview of the health trends that have been documented for boys and young men of color. The next section presents a short discussion of the concept of the “health home” in general, and then a more in-depth discussion of several of the primary models employed in health home projects around the country. The discussion of models will also attempt to extract some of the best practices from the programs that are most applicable to improving the health outcomes of BMoC in California. Finally, the brief concludes with several more broad-based policy recommendations for developing health homes in California that serve BMoC.

Overview of the Health Care Status of Boys and Young Men of Color

Boys and young men of color generally have less access to care and poorer health outcomes than both white young men and women of any race in the United States.³ Though not a comprehensive list, several key health

1. ALAN NELSON AND BRIAN SMEDLEY, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” Institute of Medicine, Board of Health Sciences Policy, National Academies Press (Washington, DC: 2003): 5.

2. There is a diverse and expansive literature on social determinants of health. A piece that may serve as a prudent

starting point for further research into this topic is World Health Organization, “Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health” (Geneva: Commission on Social Determinants of Health, World Health Organization, 2008).

3. W.K. Kellogg Foundation, “Saving Men’s Lives” (2003).

A **health home** describes the provision of comprehensive healthcare—including physical, oral, and mental—through a patient-centered approach that is designed to increase children and their families’ access to and ongoing use of a consistent healthcare venue and provider or coordinated set of providers.

indicators point to the urgency of the challenges facing this subpopulation:⁴

- African American and Latino males are more likely to have a low birth weight;⁵
- African American and Latino males also have higher odds of several chronic health conditions that require repeated, consistent care for treatment: childhood asthma requiring hospitalization, childhood obesity, and contracting HIV/AIDS;⁶
- African American and Latino males also have higher incidences of mental health issues. African American and Latino boys and young men are respectively 2.5 and 4.1 times more likely to have post-traumatic stress disorder than their white counterparts;⁷
- African American and Latino boys and young men are also more likely than their white peers to have witnessed violence inside or outside of the home, have parents who are incarcerated, or to have been incarcerated themselves;⁸
- African American men die 11.8 years earlier than white women, on average.⁹

A recent study funded by The California Endowment revealed that many of the negative health outcomes BMoC

face as a group are intimately tied to where they live.¹⁰ Specifically, many of the health problems outlined above can stem from or be exacerbated by living in a community or home situation that does not permit consistent access to quality healthcare. A disproportionately high number of BMoC face both mental and physical health issues, an already complex situation that can be further complicated by the difficulty of deciphering eligibility for public programs, and then navigating between specialists for each medical issue. Given these factors, it is clear that a consistent, accessible source for healthcare services is vital to improving the health outcomes of boys and young men of color. However, the current data show that the opposite is occurring—quality healthcare remains inaccessible for many BMoC:

- Men of all races are three times less likely than women to visit a doctor, and young men of color are even less likely than white young men and boys;¹¹
- Generally, people of color (including African Americans, Asian Americans and Latinos) go without a usual primary care provider at much greater rates than whites;¹²
- While the disparity in access rates between whites and Latinos is declining, the gap is *widening* between whites and both Asian Americans and African Americans;¹³
- Over 1 in 5 young men of color between 15 and 19 years old do not have a usual source of healthcare;¹⁴
- Wide variations in insurance coverage within the Asian American and Latino communities in California are often associated with differences in place of origin and level of English-speaking ability.¹⁵

4. Another issue that this brief will not address, but which is relevant to understanding how best to confront the health issues of boys and young men of color, is the lack of health data for most populations of color other than African Americans. There is a growing body of data available for Latinos, but troublingly little data for Asian-Americans, Pacific Islanders, Native Americans and individuals who self-identify with more than one race.

5. The California Endowment, “Healthy Communities Matter: The Importance of Place to the Health of Boys of Color” (2010).

6. Ibid.

7. Ibid.

8. Ibid.

9. W.K. Kellogg Foundation, “Saving Men’s Lives.”

10. The California Endowment, “Healthy Communities Matter: The Importance of Place to the Health of Boys of Color.”

11. W.K. Kellogg Foundation, “Saving Men’s Lives.”

12. Agency for Healthcare Research and Quality, “National Healthcare Disparities Report: 2009” (Washington, DC: 2009).

13. Ibid. There are many factors which could be driving these trends in different directions, including racial differences in insurance coverage and site of usual care. See MARSHA LILLIE-BLANTON AND OTHERS, “Site of Medical Care: Do Racial and Ethnic Differences Persist?” *Yale Journal of Health Policy, Law and Ethics*, vol. 1 (2001).

14. California Health Interview Survey, “CHIS 2007 Adult Public Use File” (Los Angeles: UCLA Center for Health Policy Research, 2009).

15. WILHELMINA LEIGH, “Factors Affecting the Health of Young Men of Color in the United States: An Overview” (Washington, DC: Joint Center for Political and Economic Studies, 2004).

In California, there is a troubling decline in access to a usual source of care as boys grow older and become young men. According to data from the 2007 California Health Interview Survey, 6.9 percent of boys of color do not have access to a usual source of care. The same survey also revealed that 21.6 percent of young men of color, aged 15-21, do not have access to a usual source of care.¹⁶

Although increasing access to a usual place for care for BMoC will not solve all of the issues driving negative health outcomes, it can be a large part of the solution. Health outcome disparities are caused by many issues that are beyond an individual's control, such as the quality of education, housing and physical environments, socioeconomic opportunities, and criminal justice trends, to name just a few. While recognizing this, this brief focuses on how having a consistent access point for healthcare can mitigate other risk factors. For brevity's sake, this brief concentrates on access to medical care, including prevention services. However, this "health home" model can and should be extended to all aspects of physical and mental health. Most urgently, the need for improved access to treatment for oral, behavioral and mental health conditions could also be impacted by coordinated and consistent care.

Health coverage eligibility, enrollment, and retention also have profound impacts on healthcare outcomes, however a discussion of health insurance lies outside the scope of this brief. Clearly, not having health insurance limits access to medical care and to a health home. Hopefully, the passage of the *Patient Protection and Affordable Care Act* (*Affordable Care Act*) in 2010 may help to mitigate some of these issues for BMoC.¹⁷

Basic Definitions of a Health Home

The phrase Medical Home—which this brief refers to as "health homes" to encompass access to oral health and mental healthcare in addition to physical healthcare¹⁸—was first coined by the American Academy of Pediatrics in the 1960s, and has since come to mean many different things. At its most basic, the patient- or family-centered

medical home model is one in which the activities of the healthcare system are built around patients' needs, instead of providers'. While patient-centric healthcare may seem like an obvious concept, the vast majority of the American healthcare system has been structured around payment and administrative systems that do not designate patient access and continuity of care as top priorities.

The health home is an approach to comprehensive healthcare that aims to increase patients' access to a consistent healthcare venue and improve their ability to have a consistent relationship with healthcare providers. The iterations of the health home model vary widely, but some basic components are fairly common. The physical scope of a health home program can also vary, from a single doctor's office to an entire statewide network of state-funded primary care providers. Some of the components that may differentiate a health home from a traditional practice include:

- A primary care physician or other provider who (or whose office) serves as the nexus of a team of coordinated health practitioners and specialists
- Meetings with patients' families
- Centralized family medical record-keeping
- Coordinated tracking of both physical and mental health treatments and needs
- Proactive actions to address health risks and chronic conditions
- A personal, ongoing relationship between the primary practitioner and the patient and/or the patient's family¹⁹
- More extensive follow-up and introductory appointments with the primary care practitioner
- Electronic medical records and administrative applications
- Training for medical office staff in coordinated care, and/or electronic administration

16. California Health Interview Survey, "CHIS 2007 Adult Public Use File."

17. *Patient Protection and Affordable Care Act*, Pub. L. 111-148, 124 Stat. 119 (Government Printing Office (GPO): 2010), as amended by *Health Care and Education Reconciliation Act of 2010*, Pub. L. 111-152, 124 Stat. 1029 (GPO: 2010) ("Affordable Care Act" or ACA).

18. CHRISTOPHER STILLE AND OTHERS, "The Family-Centered Medical Home: Specific Considerations for Child Health Research and Policy," *Academic Pediatrics*, vol. 10 (4) (2010): 211-217.

19. CRAIG WEBER, "Patient Centered Primary Care: Medical Home," Power-Point Presentation, Patient-Centered Primary Care Collaborative Spring Summit, October 22, 2009.

A consistent, accessible source for healthcare services is vital to improving the health outcomes of young men and boys of color.

- Structural commitment and resources to increasing language accessibility, and/or cultural competency and sensitivity
- Measures to integrate the practice into the surrounding neighborhood and build relationships with other advocacy/support organizations in the local area
- Capitated payments or bundling, and pay-for-performance or shared savings incentive structures

Practices and health home pilot projects may choose to adopt one or more of the components that differentiate a health home from a traditional medical practice. As an example, the University of California, Los Angeles Medical Home Program has four main components:

1. A formal, 1-hour intake appointment;
2. 40 minute follow-up appointments (double the average follow-up time);
3. A bilingual liaison to help families navigate the medical system; and
4. A family binder to store children's medical records in a single location.²⁰

Do Health Homes “Work?” Can They Work for Boys and Young Men of Color?

The health home approach to providing healthcare has been growing in popularity as pilot projects and studies over the last several decades have begun to show results indicating that health homes can reduce costs, improve health outcomes and increase patient satisfaction—especially in communities facing severe healthcare challenges. Part of the appeal may also stem from the fact that health homes can be used to promote access to care, even in uninsured communities. In 2007, four of the principal associations for healthcare providers in the U.S.—the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association—endorsed health homes in their “Joint Principles of the Patient-Centered Medical Home.”²¹

However, program evaluations of health homes have been fairly limited, and the results are inconclusive on which models are most successful.

- The **Voices of Detroit Initiative**, which is a collaborative health home system targeting uninsured adults reported a 42 percent reduction in uncompensated care costs during the first ten years of the program.²²
- An evaluation of the **Pediatric Medical Home Program at UCLA** for children with special needs revealed that among medically fragile pediatric patients, participation in the health home program was associated with a 55 percent reduction in emergency room visits.²³
- A recent study of the **Patient-Centered Medical Home National Demonstration Project** showed that gains in patient health outcomes were modest. Patient satisfaction scores stayed the same or declined after implementation of the health home program. Study designers hypothesized that the amount of disruption for providers and office staff in many of the demonstration practices “trickles down” to patients and

20. NANCY FOWLER LARSON, “Medical Home Concept for Medically Fragile Children Significantly Decreases ED Visits,” *Medscape Medical News*, March 19, 2010.

21. American College of Physicians, “Joint Principles of a Patient-Centered Medical Home Released by Organizations Representing More than 300,000 Physicians,” Press Release, American College of Physicians, March 5, 2007, available at <http://www.acponline.org/pressroom/pcmh.htm>.

22. LUCILLE SMITH, “Voices of Detroit Initiative: Taking Care of the Uninsured: A Path to Reform,” PowerPoint Presentation, National Congress on the Un/Under-Insured, September 2008.

23. AMY ALBIN, “Novel ‘medical home’ program for pediatric patients, families, cuts ER visits in half,” UCLA Newsroom, March 16, 2010, available at <http://newsroom.ucla.edu/portal/ucla/study-shows-pediatric-residency-154162.aspx>. This type of evidence is not limited to urban programs. A study of adolescents in a rural setting also showed a drop in emergency room visits after enrollment in the medical home program. SHERYL RYAN AND OTHERS, “The Effects of Regular Source of Care and Health Need on Medical Care Use Among Rural Adolescents,” *Archives of Pediatric and Adolescent Medicine*, vol. 155 (2) (2001).

reduces their perception of the quality of the experience. If that is the case, they posit further that these negative effects on patient satisfaction may diminish over time.²⁴

- A Commonwealth Fund survey in 2006 demonstrated that two-thirds of both insured and uninsured adults in health homes receive preventive care reminders (for services like cancer screenings), as compared with only half of insured and uninsured adults without health homes. The same survey showed that those who receive preventive care reminders, both insured and uninsured, have higher rates of actually receiving preventive care measures like cancer screenings.²⁵
- The 2006 Commonwealth survey also found that health homes may reduce racial health access disparities, regardless of insurance status.²⁶

While the current evidence is promising in regards to emergency room visit reductions and increased utilization of preventive measures like screenings, it is limited and carries many caveats. Reliance on survey data for understanding patient health outcomes can be challenging. Like any innovative approach, the health home has particular strengths and weaknesses, especially in early stages of development. The healthcare needs of BMoC may be particularly suited to the strengths of the health home model, but further data must be collected in order to design programs that are most effective for this community.

Health Home Programs: Overview and Best Practices

The Affordable Care Act may provide greater impetus for developing health home models in California in two respects. First, by attempting to provide most Americans with insurance, the *Affordable Care Act* begins to address one significant barrier to accessing healthcare. Second, the law creates incentives for pilot health home projects.²⁷

In California specifically, Healthy San Francisco and the UCLA Pediatric Medical Home Program are two of the largest of numerous public hospital and clinic-based health home programs in place across the state, each having varying elements of the health home components discussed above.²⁸ Legislation passed by the California legislature in October 2010 renewed the state's Medicaid 1115 waiver, and included provisions for establishing new health home programs (SB 208 and AB 342). With so much groundwork being laid for health homes in California, it will be especially important to build in health access opportunities for BMoC in particular.

Though health home components can be very different from program to program, there are three basic orientations that inform how health home models can best serve the healthcare needs of BMoC. This brief is not intended to be a comprehensive review of all of the health home projects around the country, but will attempt to extract useful practices from examples of each model.

- Model One includes programs that are focused on establishing primary care provider-centered networks and enhancing coordination of care.
- Model Two focuses on practices that emphasize the central role of patients' families in efficient and effective healthcare delivery.
- Model Three includes programs that attempt to develop the payment and reimbursement incentives necessary for healthcare providers and practitioners to deliver comprehensive, collaborative care in a health home.

Model 1: Networks, Care Coordination, and Team Care

The first model includes programs that are designed to give patients access to a coordinated care team and establish an ongoing relationship between patients and a primary care provider. One salient example of this type

24. CARLOS ROBERTO JAÉN AND OTHERS, "Patient Outcomes at 26 months in the Patient-Centered Medical Home National Demonstration Project," *Annals of Family Medicine*, vol. 8 (Supplement 1) (2010). It is also important to note that patient satisfaction scores can, unsurprisingly, be quite sensitive to patient demographics, and some studies have shown that race and ethnicity may be correlated with differing expectations of service. These considerations are of course, in addition to the possibility that objective quality of service may vary by race of the patient. See GARY YOUNG AND OTHERS, "Patient Satisfaction with Hospital Care: Effects of Demographic and Institutional Characteristics." *Medical Care*, vol. 38 (2000:3).

25. AC BEAL AND OTHERS, "Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Care Quality Survey" (New York: The Commonwealth Fund, 2007).

26. Ibid.

27. The *Affordable Care Act* calls for a Center for Medicare and Medicaid Innovation (CMI) to be established on January 1, 2011. The CMI will have the authority to launch and evaluate patient-centered medical home pilots. ACA § 3021.

28. For a list of the public hospitals with medical home programs, see: California Association of Public Hospitals and Health Systems, "Medical Homes in Safety Net: Spotlight on California's Public Hospital Systems" (2010).

The strengths of the health home model—which allow it to deliver patient-focused, comprehensive and consistent primary care—may be well suited to address the health outcomes and challenges faced by boys and young men of color in California.

of program is **Healthy San Francisco**. The applicability of this model to a program targeting BMoC is high because it serves a very diverse group of patients that face many of the same challenges as the target population. However, when assessing whether the Healthy San Francisco model can be replicated, it is important to note that it is a geographically-based program in an environment with a relatively unique level of political will to ensure universal access to health-care services.

Healthy San Francisco is a local program designed to give uninsured city residents under age 64 access to consistent primary care and healthcare services. Program participants pay a quarterly participation fee based on a sliding scale according to income, and choose a health home from a list of participating clinics and hospitals. After enrolling, participants are encouraged to make an initial appointment with their health home and newly assigned physician as soon as possible, which three-quarters of participants reported doing.²⁹ As Healthy San Francisco participants visit providers and move through the health home system, their medical records are kept electronically in a single, provider-accessible location on the web.

Healthy San Francisco's program organizers have emphasized the program's ability to provide comprehensive, affordable healthcare through a coordinated network of providers connected to the health homes, a clear,

accessible cost structure and simplified enrollment.³⁰ A 2009 survey of program participants showed that 86 percent of patients felt they had a usual place of care. More significantly, 73 and 66 percent of those with chronic conditions or in fair or poor health, respectively, reported having a regular doctor or nurse that they see.³¹ However, those who describe their mental health status as fair or poor had higher rates of reporting that one or more medical tasks—like getting specialty appointments or medical advice on the phone—became more difficult once they enrolled in Healthy San Francisco.³²

Lessons from Healthy San Francisco

- For BMoC facing multiple physical and/or mental health issues, structural measures—like the pre-established network of care providers, clear and accessible cost structure and compulsory reminders to have an initial visit—that create a more consistent provider-patient relationship may increase coordination and effectiveness of multiple treatment programs.
- Healthy San Francisco's shift in indigent healthcare from emergency care to primary care may also help to diagnose underlying mental health issues in BMoC earlier, and lead to more effective treatment regimens.
- Further development is needed on how the coordinated network serves patients with mental health needs. To improve the program for BMoC with mental health needs, a health home program could focus on incorporating healthcare coordinators who specialize in working with patients requiring mental health treatments.
- To better accommodate the programmatic needs of patients with mental health issues, a health home program could improve and increase the training that its customer hotline representatives and office staff receive.
- Healthy San Francisco's embrace of new health information technologies could serve as a model for other programs seeking to enhance patient access through technology. The program's widespread use of electronic medical records and web-based access to patient

29. Kaiser Family Foundation, "Survey of Healthy San Francisco Participants" (2009), available at <http://www.kff.org/kaiserpolls/upload/7929.pdf>.

30. TANGERINE BRIGHAM, "Universal Access to Care: Healthy San Francisco," PowerPoint Presentation, American Public Health Association 136th Annual Meeting, October 2008.

31. Kaiser Family Foundation, "Survey of Healthy San Francisco Participants."

32. Ibid.

data and clinic assignments could be duplicated in other programs in order to better facilitate coordination of mental and medical healthcare.

- Additionally, Healthy San Francisco has implemented a centralized electronic application program. One-e-App, as the application program is called, digitizes enrollees' supporting documentation and stores it online, so it can be easily accessed for annual renewal and application to other public programs. The One-e-App is set up to reduce barriers to renewal and may help to ensure more consistent coverage for participants, and could thus be an important component in programs that target BMoC.

Model 2: Family-Centered Care

Family-centered health home models recognize the prominent role played by patients' families and their capacity as caregivers, and attempt to empower family members in medical decision-making. Putting family members at the center of care may seem logical, but can also require a delicate balance when providers and family caregivers do not agree on treatments, or on the family's capacity to provide medical support at home. Additionally, family-centered care is a challenge when parents or caregivers are simply not physically engaged or are unable to consistently support a patient.

The Pediatric Alliance for Coordinated Care (PACC) in Massachusetts conducted a two-year pilot study to assess the impact of introducing family-centered health home components into six primary care practices serving children with special health needs. The evaluation of the PACC pilot program showed that patient family satisfaction rates remained high throughout the project, and that there were decreases in hospitalizations and the number of parents who missed 20 or more days of work due to their children's health issues.³³ While the health service issues facing children with special health needs are specific, and different from those confronting many BMoC, the PACC approaches to assisting families with coordinating care among specialists, often within the Medicaid system, provide helpful guidance.

The PACC pilot introduced two primary innovations: the introduction of Pediatric Nurse Practitioners (PNPs)

with designated time for coordinating care, and Local Parent Consultants (LPCs). The PNPs spent 8 hours per week coordinating pilot patients' care. Activities performed by PNPs included a house visit with each patient's family to assess needs, capacity, and environmental issues that may create obstacles to consistent care.³⁴ Additionally, PNPs established an Individual Health Plan with each family that outlined each child's health goals, resources, specialists and medical history. The Individual Health Plans were then stored in a centrally accessible location and could be shared, with parents' permission, with specialists or health consultants. PNPs also worked to reduce care burdens on family members by performing home visits when children were ill, coordinating specialist appointments at convenient times and streamlining medication orders and renewals.³⁵

The LPC were volunteer parents from the local community whose children also had special health needs. LPCs acted as peer supporters and navigators for families needing assistance finding local resources and specialists for particular pediatric health issues. Additionally, LPCs sometimes acted as informal ombudsmen, communicating patient family issues and complaints to clinical staff.³⁶ Periodic PACC parent newsletters and social activities for PACC parents also enhanced parents' networks for peer support and guidance.

Other clinical staff members also appear to have played a role in the success of the PACC. Each office was equipped with a tip sheet with advice for procedures that enhance family-centered care. Also, the pilot's evaluators cited the staff's increased Spanish language capacity and translation of PACC newsletters as part of the reason white and non-white families fared equally well during the project.³⁷

Lessons from the Pediatric Alliance for Coordinated Care

- The role of the PNP as a healthcare coordinator who is designated to work specifically with the family could also be applied to health homes specifically for BMoC, especially those requiring both physical and mental health services. A PNP or individual acting in a similar capacity, whose primary task is to customize the healthcare service delivery experience to each patient's particular

33. JUDITH S. PALFREY AND OTHERS, "The Pediatric Alliance for Coordinated Care: Evaluation of a Medical Home Model," *Pediatrics*, vol. 113 (2004).

34. *Ibid.*

35. *Ibid.*

36. *Ibid.*

37. *Ibid.*

needs, could help to mitigate the multi-faceted obstacles many BMoC and their families face when seeking consistent care.

- The innovation of including LPCs could help to address several issues in designing successful health home models for BMoC. Because consultants are drawn from the same community as patient families, newly enrolled families may more readily develop trust in the health system. Further, advice and consultation from those who “have been there” both in terms of medical experiences and community environments, may be more effective for parents struggling to balance children’s health needs with other concerns.
- Health home settings allow for straightforward changes to the staff operation of clinics, which may reduce obstacles to care for BMoC. Toolkits for physicians looking to integrate better family-centered health home practices into their clinics have been developed, but none focus on improving care for this population. While the toolkit developed by the National Center for Medical Home Implementation focuses on children with special health needs, it also includes information on transitions from pediatric to adult care, an issue that is applicable to BMoC. Similar toolkits and tip sheets specifically designed for the health and coverage transitions faced by adolescents of color could also be developed for practices seeking to better serve BMoC.

Model 3: Payments and Financing

Payment and financing structures can act as a double-edged sword in advancing comprehensive patient care. One basic example of how financing systems may work against comprehensive patient care is a fee-for-service system, which creates financial incentives for doctors to see as many patients a day as possible, but not necessarily to spend enough time with each one. Or, in managed care settings with capitated

payments, doctors may feel that the per-member-per-month payments create incentives to have as many patients as possible, but not to necessarily develop in-depth relationships with each one. On the flip side, changes in the payment structure can create opportunities for collaborative care models by altering treatment incentives and re-centering health services around primary care and the relationship with the primary care provider. The growing use of a flat, enhanced per-member payment on top of current reimbursement, as in the example below, is one of several approaches being tested in order to determine the best mix of payment structures. The Patient Centered Primary Care Collaborative espouses a hybrid model to realign payment incentives with three components: 1) a monthly care coordination payment for providers; 2) a visit-based fee-for-service payment; and 3) a performance-based component founded on improvements in patient health outcomes.³⁸ Several state Medicaid programs, including those in Oklahoma, Idaho, and Alabama, have recently implemented pay-for-performance and shared savings programs in order to advance health homes.³⁹

Vermont’s **Blueprint for Health**, a statewide health coverage and access program, primarily relies on health homes and includes payment reforms. The two main components of Vermont’s financing reform have been insurers’ enhanced payments to providers and a public-private partnership among insurers and Medicaid to fund Community Health Teams.⁴⁰ The enhanced payments are paid by insurers to certified patient-centered health home providers based on the number of adult patients, on top of already established fee-for-service payments. These enhanced payments are intended to compensate the providers for additional time spent in extended visits with patients and coordinating treatment programs with other specialists on the healthcare team. These payments are also intended to create incentives for establishing the infrastructure necessary to facilitate an effective health home.

38. NEVA KAYE AND MARY TAKACH, “Building Medical Homes in State Medicaid and CHIP Programs” (Washington, DC: National Academy for State Health Policy, 2009).

39. Ibid. Pay for performance and shared savings are relatively new strategies in health homes, so limited evaluations are available. For more on the supporting evidence driving this approach in health homes, see THOMAS ROSENTHAL, “The Medical Home: Growing Evidence to Support a New Approach to Primary Care,” *Journal of the American Board of Family Medicine*, vol. 21 (5) (2008). For an evaluation of the effectiveness of pay-for-performance in primary care settings, see STEPHEN CAMPBELL AND OTHERS, “Quality of Primary Care in

England with the Introduction of Pay for Performance,” *The New England Journal of Medicine*, vol. 357 (2007). This report details a 2007 study of the United Kingdom’s national pay-for-performance policy in primary care, which showed modest accelerations in health improvement rates for patients with asthma and diabetes.

40. Vermont Department of Health, “Blueprint for Health Annual report: 2009,” January 2010, accessed at http://healthvermont.gov/prevent/blueprint/documents/Blueprint_AnnualReport_2009_0110rev.pdf. The *Affordable Care Act* also includes funding for these type of programs, ACA § 3502.

The innovative Community Health Teams are a group of professionals—including nutrition/diet coaches, public health consultants, and fitness coaches—that are assembled in each community to address patient health needs (like widespread obesity and growing rates of diabetes). In order to remove barriers to patient utilization, there are no patient copayments or other cost-sharing. The teams are jointly funded by Medicaid and the three major private insurers in the state.

Lessons from Vermont’s Blueprint for Health

- By reducing initial financial risk for practice innovations, enhanced payments may be a way to transition physicians into coordinated care models.
- Lowering financial barriers associated with having to see multiple healthcare team specialists—as the Blueprint accomplishes by requiring zero copayments for visits with Community Health Team members—may increase patient accessibility to comprehensive treatment options. BMoC with identified health risk factors may benefit from treatments that are not exclusively medical, like fitness coaching, nutrition counseling and psychological counseling.
- The Blueprint’s shared responsibility financing pool adds to the program’s scalability and enhances flexibility to adapt to different community needs. This flexibility of pooled funding could be especially important in California programs for BMoC in diverse community settings—e.g., rural, urban, highly homogeneous, or heterogeneous. However, due to the difference in population size and composition between California and Vermont, more research should be conducted into how scalability might work at much larger levels and with more heterogeneous populations.

A Note on Cultural Competence

While 25.3 percent of the U.S. population identifies as being from underrepresented minority groups, only 9.9 percent of physicians and 5.5 percent of registered

Health homes that target young men and boys of color can be an opportunity to expand culturally sensitive health resources in a community.

nurses come from those same communities.⁴¹ As a result, many provider-patient interactions may be cross-cultural. Communities of color in California are highly heterogeneous, and reflect a broad mix of immigration and migration patterns, socioeconomic challenges, languages, and social traditions and norms. In order to better reach BMoC, and reduce barriers to care, innovative care delivery models must incorporate cultural competence.

Several of the large health home evaluation studies have integrated some component of cultural competence enhancement into the program, but not as a central feature. The PACC, mentioned earlier, and the Illinois Medical Home Project included both the use of bilingual staff and translation of written materials for patients.⁴² However, while evaluations of both projects showed positive results, the effect of these features was not specifically studied.

Health disparity research shows that minority patients have better health outcomes when treated by physicians from their own racial or ethnic group.⁴³ Improving healthcare for underrepresented minority populations by diversifying the demographic makeup of medical professionals in the United States is important, but long term work. In the immediate term, health homes that target BMoC can be an opportunity to expand culturally sensitive health resources in a community. For example, the health home model’s focus on families inherently includes cultural concerns, as family structures, authority figures and roles will differ widely across the BMoC population. Another opportunity for improving cultural competence and accessibility can occur within the networks of coordinated care, which may include non-Western medicines and techniques.

Cultural competency in healthcare service delivery is a growing field of study, however a thorough review of

41. THOMAS BODENHEIMER, “The Patient-Centered Medical Home: from the Practice of the Past to the Practice of the Future,” PowerPoint Presentation, Medical Home Webinar, California Department of Health Services, February 26, 2010.

42. KRISTIN RANKIN AND OTHERS, “Illinois Medical Home Project: Pilot Intervention and Evaluation,” *American Journal of Medical Quality*, vol. 24 (2009).

43. BRIAN SMEDLEY AND ALAN NELSON, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.”

By learning valuable lessons from the health home programs already being tested and implemented in California and other states, new programs can be more innovative and effective in helping to ensure healthy lives for young men and boys of color.

emerging practices falls outside the scope of this paper. Nevertheless, providers and advocates designing health home programs for BMoC should consult the growing literature, including the National Center for Cultural Competence series on Promising Practices for ideas and innovations that may help to ensure that other components of the health home are accessible for patients.⁴⁴

Using Health Homes to Improve Health Outcomes for BMoC

Healthcare delivery system experts rightly caution that focusing on short term gains in implementing health homes is “alluring, but in the end may prove foolhardy.”⁴⁵ Instead, the development of health home models for BMoC must strike a balance between the urgency created by worsening health outcomes for this population and the need for sustainable programs that avoid replicating past obstacles to consistent care. In addition to the program-specific lessons incorporated into the analysis of the four models, several policy initiatives may create a more hospitable environment for successful health homes for BMoC.

1. Maximize the opportunities of California’s implementation of the Medicaid waiver and *Affordable Care Act*. The state’s efforts to implement federal healthcare reform should include programs that provide

healthcare navigators and other forms of assistance intended to help patients move through the healthcare system and transition smoothly from pediatric to adult care. Additionally, the *Affordable Care Act* includes new grant money intended to recognize the “added value from....patient-centered care” that can be directed towards community health teams and health home programs.⁴⁶ This funding may be an opportunity to test payment reform schemes.

2. Develop pilot programs for innovative care delivery mechanisms that increase access for BMoC living in areas with limited public services. Innovations in health information technology, like electronic medical records, may be just one component of improving the accessibility of healthcare and medical information. Telemedicine projects are being conducted in several states, as are physician and nurse home-visit programs.⁴⁷ For BMoC and their caregivers living in areas with limited or inconsistent public transportation or childcare services, healthcare service delivery innovations may encourage more consistent utilization of the health home. Pilot programs should, however, be carefully evaluated to ensure patients still receive high quality care.

3. Conduct further study of the use of schools as health homes. Most BMoC already have a single, consistent physical location they “belong” to: their local public school. Ideas for developing schools as a possible health home for BMoC should be explored further, and take into account whether BMoC feel comfortable in their school environment, how poor attendance may affect access to care, and whether there are privacy issues that need to be resolved when medical records and school records are linked.⁴⁸

44. The National Center for Cultural Competence at Georgetown University is a good place to start investigating the topic of cultural competence in medicine, available at <http://www11.georgetown.edu/research/gucchd/nccc/>. For an evidence-based study of the importance of cultural competence in health care settings, see TAWARA GOODE AND OTHERS, “The Evidence Base for Cultural and Linguistic Competency in Health Care” (Washington, DC: The Commonwealth Fund, 2006).

45. DIANE RITTENHOUSE AND STEPHEN SHORTELL, “The Patient-Centered Medical Home: Will it Stand the Test of Health Reform?” *Journal of the American Medical Association*, vol. 301(19) (2009).

46. ACA § 3502(c)(3)(F).

47. For more on telemedicine pilot projects in New York and Florida, see Lucile Packard Foundation, “Models of Care for Children and Youth with Special Health Care Needs: Promising Models for Transforming California’s System of Care” (2009), available at <http://www.lpfch.org/nationalmodels/fullreport.pdf>.

48. For a snapshot of the current distribution of school-based health centers, see The National Assembly on School-Based Health Care, “School-Based Health Centers: National Census, School Year 2007-2008” (2008).

4. **Develop and fund community-based outreach and education programs aimed at reducing healthcare treatment stigma.** Some BMoC come from communities that have historically faced and continue to face discrimination and injustice from public institutions, including healthcare providers. Additionally, despite the frequency of mental and behavioral health issues in their communities, BMoC may have or perceive stigmas against receiving behavioral health treatment in particular. Reducing these fears and biases against seeking treatment will help bridge the gap between having insurance and having healthcare.
5. **Increase resources for development of a more diverse primary care workforce in California.** The state of California was recently granted \$10 million in health profession development grants by the federal Department of Health and Human Services. Part of the grant money is directed towards strengthening the pipeline for a more diverse healthcare workforce.⁴⁹ California should direct complementary state funds to programs that develop diverse healthcare professionals in communities not closely tied to federal grant recipients, and consider programs specifically encouraging men of color to join the healthcare workforce.
6. **Study the ways in which behavioral, mental and oral health programs can be incorporated in health home programs for BMoC.** Although space does not permit a full discussion of behavioral, mental and oral health issues in this brief, prevention and treatment challenges in these areas are acute for many BMoC.⁵⁰ Currently, few health home programs incorporate both behavioral health and dental coverage.

CONCLUSION

The strengths of the health home model—which allow it to deliver patient-focused, comprehensive and consistent primary care—may be well suited to address the health challenges faced by BMoC in California. With careful design and rigorous evaluation, health homes could also work well with the expanded access to insurance created by the *Affordable Care Act*, perhaps changing the healthcare landscape for BMoC. Additionally, recognition of the time needed for a process like the creation of health homes to translate into improved health outcomes for BMoC should be central from the outset. By learning valuable lessons from the health home programs already being tested and implemented in California and other states, new programs can be more innovative and effective in helping to ensure healthy lives for boys and young men of color.

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49. Department of Health and Human Services, “HHS Awards \$159.1 Million to Support Healthcare Workforce Training,” News Release, Washington, DC, August 5, 2010. A full chart of state-by-state grant awardees and grant categories is available at http://www.hhs.gov/news/press/2010pres/08/state_charts.html.

50. For more on oral health issues facing boys and young men of color, see BURTON EDELSTEIN, “Disparities in Oral Health and Access to Care: Findings of National Surveys,” *Ambulatory Pediatrics*, vol. 2 (2002).