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Substance Abuse and Mental Health Services Administration  
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**PATH** Projects for Assistance in  
Transition from Homelessness

## Spotlight on PATH Practices and Programs

### The Medical Home



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Homeless Programs Branch, Division of Service and Systems Improvement, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 1 Choke Cherry Road, Rockville, MD 20857.

Questions or comments related to this document should be directed to Mattie Curry Cheek, PhD, Director, PATH Program, at 240-276-1745; to the Center for Social Innovation at 617-467-6014; or emailed to [path@samhsa.hhs.gov](mailto:path@samhsa.hhs.gov).

## Additional SAMHSA Resources

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## Wally's Story

Wally drifted in and out of homelessness his entire adult life. He often lived with acquaintances, on a sofa, or in the back seat of his station wagon. He never had insurance or a primary care provider. He never needed a doctor. That is, until a car struck him and he sustained a fractured pelvis and ruptured spleen. His hospital stay was marked by months of medical visits and therapy sessions. Upon discharge, he received instructions to go home, rest, and follow-up with his primary care physician. Wally didn't have a home, a place to rest, or a primary care physician.

Wally was frail, weak, and vulnerable when a PATH provider met him while conducting outreach. The outreach worker took him to a Health Care for the Homeless (HCH) clinic for evaluation. Wally had no medical records. Therefore, the first step for the primary care team was to get all of the information they could and create a "medical home" for Wally—a place where he could receive all of his medical care services and support. Working in collaboration with the HCH providers and staff, the PATH team was able to open a Social Security Insurance (SSI) case, and within 3 months Wally received his first SSI disability check. He quickly moved into supportive housing.

For years, Wally continued to see the medical providers at the HCH clinic. When Wally passed away, his primary care providers worked with the medical examiner and ensured that a complete set of medical records was available. They helped contact Wally's next of kin and made arrangements for a memorial service. Wally's medical home served more than just a health care services role—it became a true place of rest and comfort. By connecting Wally with a medical home, the PATH team helped to guarantee he had true dignity...in life and death.

This Spotlight provides a conceptual background to the medical home, the current state of health care policy, and the current state of primary care. It also features four innovative PATH providers who successfully integrated primary care services into their programs. This resource concludes with key tips for PATH programs and resources for further study.



## The Medical Home

In 1976, the American Academy of Pediatrics introduced the concept of Patient Centered Medical Home, or simply “medical home.” The basis of medical home is the premise that quality medical care requires continuity in the provider and patient relationship. According to the Future of Family Medicine Project, a medical home should be “accessible, accountable, comprehensive, integrated, patient-centered, safe, scientifically valid, and satisfying to both patients and their physicians” (Martin, 2004). Above all else, the modern medical home is about a relationship between a medical provider and a patient that is grounded in compassion and based on open communication and holistic, longitudinal care.

## Patient Protection And Affordable Care Act

In March of 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA). Effective January 1, 2014, the law includes a large number of health-related provisions that expand access to health care for homeless and underserved populations. From 2010 to 2014, the PPACA will expand Medicaid eligibility, subsidize insurance premiums for individuals with income up to 400 percent of the federal poverty level, and provide incentives for businesses to offer health care benefits to their employees. It will also prohibit the denial of coverage/claims based on patients’ pre-existing conditions, establish health insurance exchanges that allow individuals and small businesses to get better prices and a larger variety of health insurance options, and support the expansion of funding for medical research.

The expansion of Medicaid eligibility has the potential to increase access to care for individuals with income up to 133 percent of the Federal poverty line. This expansion includes adults living without dependent children—a large percentage of people experiencing homelessness. Equally, the PPACA will expand access to health care for people collectively bracketed in the lowest socio-economic categories, supporting employed individuals who pay more than 9.5 percent of their income on health insurance premiums. It also ensures that individuals are able to purchase a state-controlled health insurance option.

## What Is Primary Care?

Primary care is holistic and person-centered; it connects physical and mental health, substance use, and psychiatric services into a focused care delivery environment. In 1978, the Institute of Medicine (IOM) defined the essence of primary care as “accessible, comprehensive, coordinated and continual care delivered by accountable providers of personal health services” (p. 1). Underlying this definition is the idea that primary care is longitudinal and sustainable. Primary care is relationship-driven and requires that all team members collaborate to provide the best care possible.

Increased access to primary care reduces the need for, and unnecessary use of, emergency department services with a resulting decrease in overall health care costs (Gill, Mainous, & Nsereko, 2000; McGuire, Gelberg, Blue-Howells, & Rosenheck, 2009). Because of improved health outcomes in the management of chronic illness, researchers advocate for coordinated care that links consumers to primary care (Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005; Menec, Sirski, Attawar, & Katz, 2006; Strehlow, Kline, Zerger, Zlotnick, & Proffitt, 2005).

Primary care addresses co-occurring disorders, and improves quality of life. Dr. Jim O’Connell, President of Boston Health Care for the Homeless, promotes integrated care models to ensure that providers address all of the needs of the patient. “We are dealing with a population that has co-occurring medical illnesses, substance use disorders, and mental illnesses. Treatment must be fully integrated where you have medical care with mental and substance abuse care. I can see patients with our psychiatrist and deal with the whole person” (Waldroupe, 2010). Creating care linkages is fundamental to primary care—and PATH.



## Primary Care And PATH Outreach

As PATH programs focus on identifying and assisting people experiencing homelessness and serious mental illnesses and co-occurring substance use disorders, connecting these individuals to primary care services is essential. This connection results in many positive outcomes. Joyce and Limbos (2009) found that facilitating access to primary care for people experiencing homelessness enhances identification of mental illness, and thereby improves treatment outcomes. Many housing models require individuals' engagement in services before they are eligible for housing. Therefore, identifying mental illness and beginning treatment are often steps PATH consumers must move through before they transition from the streets into housing.

Although many programs struggle to find available health care services, PATH providers recognize the importance of linking consumers to primary care. A few PATH programs use their ingenuity and creativity to develop collaborations that effectively deliver primary health care to people experiencing homelessness.



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## Community Health Center of Burlington

Burlington, VT

<http://www.chcb.org>

The Community Health Center of Burlington (CHCB), located in the downtown area, operates the PATH program in Burlington, VT. The program addresses fragmentation of services, one of the main barriers to primary care access and utilization. As Erin Ahearn, PATH Project Director explains, “We decided to build a ‘one-stop shopping’ experience for consumers. Our programmatic goal was to make the transition from one service to another as easy and seamless as possible.”

The Burlington PATH program works in collaboration with CHCB and HCH to provide medical, dental, and mental health services “under one roof.” Medical services are available 5 days a week at a half-day clinic and nursing services are available 40 hours per week. Consumers can see their PATH provider, request a referral into the primary care clinic, and see a doctor or nurse all in the same day. “We offer everything from basic testing and evaluation (e.g., TB skin testing and chest x-rays) to more advanced procedures and referrals to specialists. We even have a diabetes management program and smoking cessation program available on-site,” recounts Ms. Ahearn. While research shows that reducing fragmentation

by offering services in a “one-stop shopping” environment is an effective way to deliver integrated care (Alfano, 2004; Hornik & Winarski, 2000), creating such an effective program is not always easy.

PATH consumers in the Burlington program link with primary care through an outreach worker in the community. Once consumers complete a short intake form, they can see a primary care provider that day. The Burlington program has ongoing consumer registration, sees 1,300 patients each year in their HCH program, and provides 14,000 primary care visits annually in the CHCB program.

A remuneration system to help offset the costs of primary care services is critical to the survival of any PATH and health care collaboration. The state of Vermont mitigates this challenge with strong Medicaid and state Managed Care Plans. Every person in the state with a birth certificate and eligibility certification qualifies for insurance. Approximately half of the PATH consumers seen in the Burlington program are uninsured and with a little bit of help, most consumers have the skills to self-enroll into the state Medicaid program. Not every state has such a generous Medicaid program. In fact, many states have limited to no enrollment open for Medicaid. For many PATH providers in other states, linking consumers to primary care services requires on-going advocacy and follow up.



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## Ocean Park Community Center

Santa Monica, CA

<http://www.opcc.net>

Expensive emergency department (ED) services are the main access to primary care services for many people who do not have health care insurance or access to a usual and customary medical home. The Ocean Park Community Center (OPCC) in Santa Monica, CA recognized the high utilization of ED services for non-emergent medical needs by their PATH consumer population. They worked with local health care service organizations to develop a medical home clinic at their access and drop in center (a service delivery center where consumers gain access to a number of different services).

According to Debby Maddis, Director of Housing and Special Initiatives, "We knew we needed to offer medical services on-site, so we built two medical suites in our facility for the Venice Family Clinic (VFC) medical staff." The two-room clinic soon grew into a medical home for consumers served through the OPCC/VFC programs. The OPCC and VFC also developed a 10-bed respite care program where consumers can live while recovering from health-related illnesses. Through a number of collaborative agreements with partner agencies in the Santa Monica area, OPCC PATH consumers have access to dental, mental health, and substance abuse treatment.

When asked to describe the real strength of the collaboration, Ms. Maddis reports, "I think the best way for me to really tell you about our success is to tell you about 'Sally' (not her real name)." Sally is an 81-year old woman who spent over four years on the streets of Santa Monica. The OPCC program connected with Sally upon her referral to the respite care program from St. John's Health Center with cardiovascular disease and psychiatric needs. Up until that point, the PATH team was unable to engage Sally into care. During a 3-year period, Sally visited

When asked why OPCC developed their primary care partnership, Ms. Maddis replies:

"Our program was developed with input from Venice Family Clinic and area emergency departments and a strong local community hospital (St. John's Health Center). The major theme was the over-utilization of EDs for chronic medical care services by our PATH consumers. We worked with various stakeholder groups in our communities to formalize our model. After we had a clear idea of what we hoped to accomplish with our project, we sought funding from a variety of resources. Our funding came through a series of grants and foundation dollars from Tides Foundation, The California Endowment (Community Clinics Initiative planning grant), L.A. County Homeless Prevention Initiative (funding for health and respite care) and the Hilton Foundation (helped to fund the supportive services). Our program was born from necessity to assure that our consumers had quality primary care services."

the hospital 55 times. Since her enrollment in the OPCC program and with the primary care partnership with VFC, Sally reconnected to her family and lives in permanent housing. With regular primary care from VFC providers, her heart condition stabilized and she has not required hospitalization in a year.

Like many PATH programs across the country, OPCC realizes the need for collaborations. By building effective partnerships in the Santa Monica area, OPCC enhances services for people experiencing homelessness. . No one program can be everything to every consumer. Programs can, however, collaborate with partners in human services delivery to enhance care.



## Maricopa County Health Care for the Homeless and PATH Program

Phoenix, AZ

[http://www.maricopa.gov/Public\\_Health/Services/Homeless/default.aspx](http://www.maricopa.gov/Public_Health/Services/Homeless/default.aspx)

For many PATH programs, the question is, “How can we link our consumers into care when there are so few available resources?” In Maricopa County, AZ, the PATH program and the local HCH clinic work together, with 60 percent of PATH consumers accessing primary care services. Services include general medical care, prenatal care, dental care, medical equipment (wheel chairs, crutches, walkers), pharmacy assistance, and help obtaining Social Security Administration benefits (e.g. SSI/SSDI).

The Maricopa County PATH program and the HCH clinic are located on a Human Services Campus in downtown Phoenix with everything under one roof. “We have consumers with heart disease or diabetes and medical illnesses that haven’t been addressed at all or since they left another state. Getting those services started for them as well as getting the benefits they deserve, is something that we help them with,” states Ken Curry, Outreach Director for Southwest Behavioral Health Services (SBH). SBH is a behavioral health contractor at the campus. In addition, SBH and Mr. Curry were instrumental in the development of the Human Services Campus model and the holistic level of services delivered at the campus.

The Maricopa County Human Services Campus consists of five buildings that include shelter beds, a Safe Haven facility, a full service medical and dental clinic, and over 400 beds for transitional housing. In addition, the program offers 25 shelter beds for consumers with severe mental illness.

Mr. Curry asserts that one of the best tools for linking consumers to primary care services is a “very knowledgeable” staff of PATH providers. “One thing is seeing the need, but another thing entirely is being able to prioritize so consumers get their needs met. We work with community partners to build the bridges of care delivery.”

Integrated services are not always a straight line of development for the Maricopa County PATH program. Mr. Curry explains that when he started with the PATH team in 1988, just a few service providers were connected. He states that one of the “dreams” of the early Homeless Consortium Group was to have a campus that would be a “one-stop” center of homeless services. The Consortium Group convinced the City Council, the Mayor’s Office, and a broad group of stakeholders to invest their time and energy in developing the campus.

“It is still a work in process, we’re here together on campus, but sometimes we forget we’re a shared agency—it takes some getting used to,” reports Ken. “Our goal was, and still is, to provide very comprehensive care. We are not the ‘end all and be all,’ but our staff is very dedicated to physical and mental health care. Having a proactive staff that really cares about consumers is the key to our success and the reason our program is so effective at linking PATH consumers into primary care.”

It is tempting to believe that simply developing a “one-stop shop” campus will greatly enhance services delivery. The Maricopa County Human Services Campus is successful because it builds strong bridges of support between agencies and organizations. It has effectively fostered collaboration.



## Circle Family Health Care Network

Chicago, IL

<http://www.circlefamilycare.org>

For many consumers, the structural barriers to accessing primary care services are too great to overcome. Once consumers identify their medical needs, many find it challenging to take the next step and advocate for needed services, many may not even be able to put words to their symptoms.

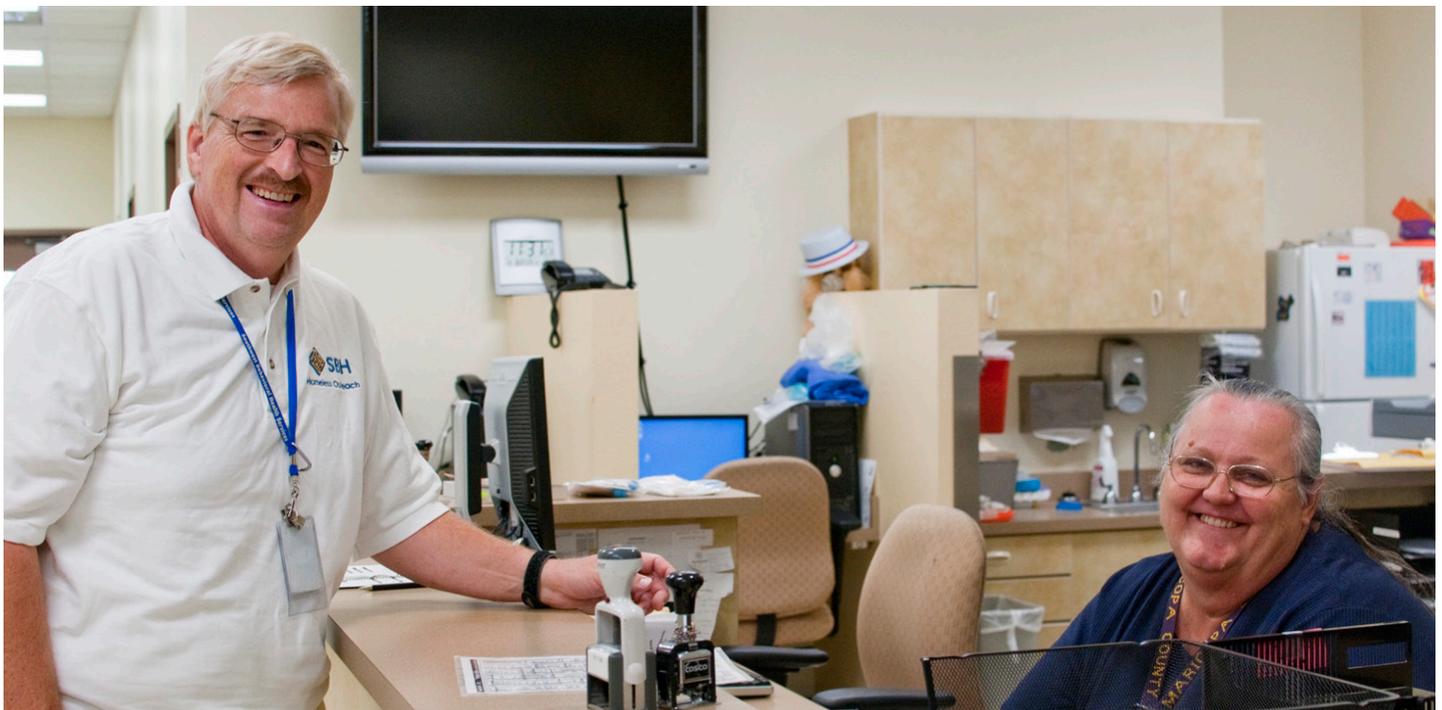
Circle Family Health Care Network (CFHCN) finds that many people who live on the street will not come to a traditional medical office. To overcome these barriers, CFHCN brings medical and health care services directly to their consumers. “Most consumers come to us and they did not have any type of primary care,” reports PATH Program Director Cora Montgomery. “Our focus is getting them connected with all of their needed services. We have a mobile health team that consists of a doctor, registered nurse and a therapist and primary health care clinics at four sites.” They provide services at 26 homeless shelters and mobile medical clinic locations.

Circle Family Health Care Network started their outreach program about 8 years ago. When they received a grant from Heartland Alliance to reach out to uninsured and underserved

consumers, CFHCN developed a community health center model and became a Federally Qualified Health Center (<https://www.cms.gov/MLNProducts/downloads/fqhcfactsheet.pdf>).

The program links consumers to primary care from the moment the outreach team engages them. “As soon as we receive the paperwork from the mental health team, that’s their first connection with a medical provider and right there they are passed onto primary care,” notes Ms. Montgomery. She describes the “continuum of services” at CFHCN as a long table—when consumers finish with the medical aspect, then it is on to the next section, where they have access to a therapist and case manager.

Primary care services offered through CFHCN include everything from testing for tuberculosis and vaccinations to focused medical encounters like joint and back pain. In addition, the program provides HIV counseling and testing services, along with hepatitis testing. In addition to the primary care services offered at CFHCN, the program links consumers to subsidized housing, medical coverage through public assistance, help with optometric needs (e.g., eye glasses), and referrals for dental care. The program partners with the University of Chicago School of Dentistry to get consumers free or low-cost dental care. These linkages and partnerships are essential for the success of CFHCN.



## KEY TIPS FOR PATH PROGRAMS

### Address Service Fragmentation

Fragmentation of the human services delivery system requires consumers to travel to several different locations for services (Gallagher et al., 1997; Hornik & Winarski, 2000). Fragmentation also decreases communication and coordination of care among service providers. Mobile service delivery units, like CFHCN, are an innovative way to meet people where they are. A lower cost option is to invite primary care providers to join the PATH team on outreach to provide basic medical care on the streets and in novel care delivery environments. Integrating medical and behavioral health services into a single care delivery team means consumers can have all of their care needs addressed at every health care encounter.

### Promote Co-Location of Programs

The most efficient way to address human services delivery fragmentation is to provide different services in the same location. In Burlington, VT, co-location provided consumers with seamless access to primary care services. According to Ms. Ahearn, "Once we moved our services into a single geographic location, about 90 percent of our consumers started going to primary care services." In Maricopa County, the Human Services Campus was a dream that seemed unattainable. By thinking creatively, getting the City Council and Mayor's Office interested, and finding funding through the Piper Trust Fund, it became a reality. The campus-style service delivery environment means that consumers can get a number of their care needs met in a single location.

### Create a Network of Community Partners

Not every community has the resources to build a multi-million dollar Human Services Campus, but programs can bring services into a consolidated format without having the services in one geographic area. Creating a network of community partners allows PATH programs to access primary care services. Maricopa County believes the personal connection with other agencies is the key to building a connected set of services. Mr. Curry

states, "We try to make a personal connection. We will explain what we do and who our agency is, and once we do that it works really well to build bridges of collaboration for our consumers."

Partnerships, and the access to additional services and knowledge that come from collaborative care delivery systems, are critical to the work of all PATH providers. Reach out and talk with agencies that offer human services in your community. Partners may be similar to or very different from your own program.



## Collaborate with Local Emergency Departments

In Maricopa County, one of the biggest “bridges” that Mr. Curry and his staff continually work on developing and maintaining is with metropolitan area emergency departments:

**“We are working on a couple of committees; one of them is Maricopa County Crisis Coordination Committee. We are working to improve the communication between ED staff and our team. The local EDs and the level-two psychiatric facilities use a pink form to refer consumers to our office. When we see a consumer coming in with a pink form, we know that they were just released from the psychiatric facilities or ED. Called the “Pink Slip Referral Process,” this system works well because the EDs and the level two psychiatric facilities are the only agencies using our pink form.”**

Developing simple, efficient mechanisms for referring consumers from one level of care and service engagement to another level is critical to ensuring primary care linkages.

## Find Ways to Track Consumers

Homelessness is inherently a transient state and people often must move from shelter to shelter or town to town and do not have an address or telephone. To overcome this challenge, CFHCN works with shelters to create a messaging system. The messaging system links consumers to a telephone answering service where they can pick up voicemail from CFHCN and other agencies. The messaging system is a communication lifeline for many consumers and a mechanism for their primary care service providers to coordinate their care needs.

## Trusting Relationships are Essential

Ms. Montgomery from CFHCN notes that many consumers have difficulty with trust and trusting relationships, as they were “treated so badly in the past and have a hard time trusting anyone.” She states that “getting past that barrier” of mistrust is the key to engaging consumers in services. Ms. Ahearn, from CHCB, adds that providers have to work hard to earn trust, but it will help create change: “We realized that patients trusted us and we had to do the best we could to get that trust to help them create change. Our PATH providers will oftentimes go with their consumers to their primary care visits. This gives them support and helps to solidify the relationships.” Developing relationships is what PATH providers do best, which makes PATH a valuable program for collaboration with clinics, HCH programs, and other health care providers.

## Create Memorandums of Understanding

Memorandums of Understanding (MOUs) with local hospitals can help track consumers, coordinate care, and obtain data for program evaluation. Such MOUs between PATH providers and hospitals create mechanisms to share consumer information and collaborate around consumer care coordination. At OPCC, Ms. Maddis believes that the development of MOUs with their local hospitals helped to open a number of doors of opportunity for their consumers. As an example, “Two MOUs allowed the collection of consumer data from local hospitals in Santa Monica and really changed the way we collaborate with these institutions.”

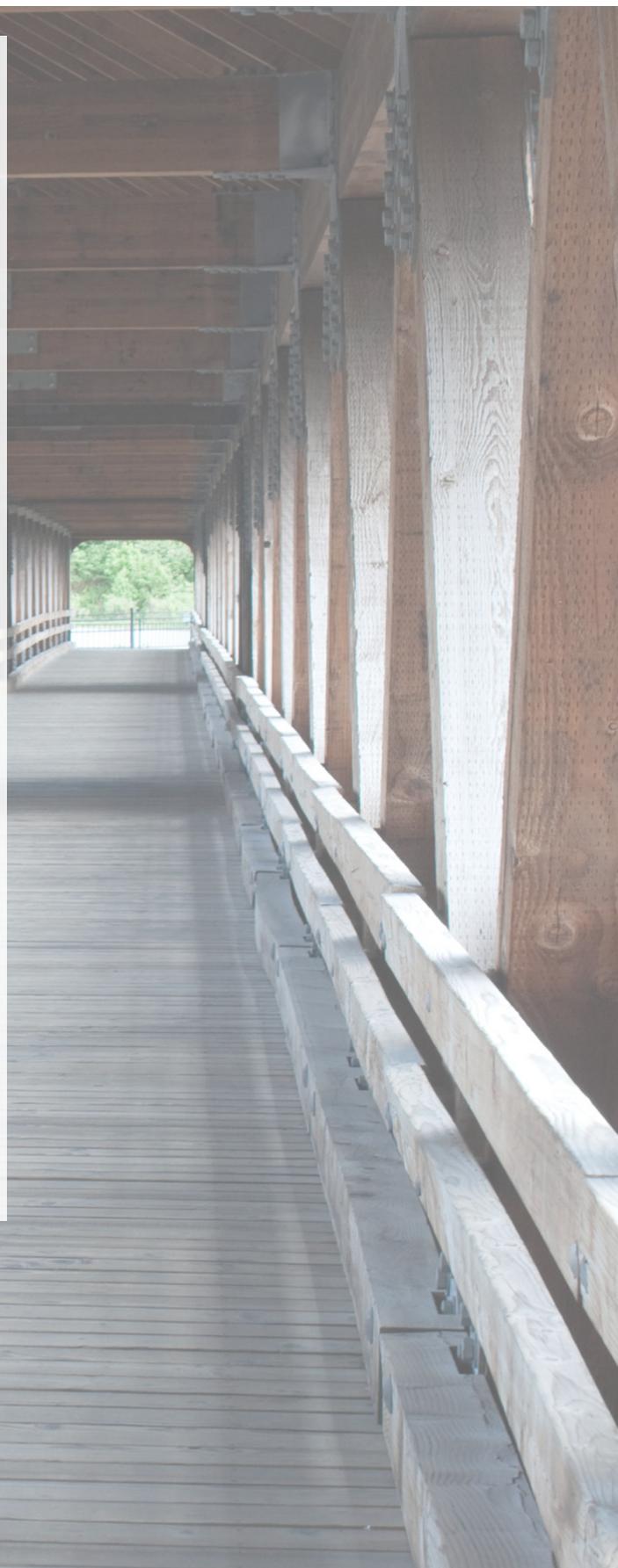


## Where To Go From Here?

Whether called a medical home or a primary care relationship, consistent primary care access and utilization leads to improved identification and treatment of medical, substance use, and mental health issues. Early identification, consistent care coordination, and relationships all lead to more effective primary care. Benefits of primary care include the improved management of chronic illness and improved relationships between patients and the medical community.

While this Spotlight may make connecting PATH consumers to primary care look easy, making these connections can take a lot of work. The difficulty of obtaining medical insurance can prevent people from receiving care and there are no easy solutions for overcoming this barrier. Providers in this situation need to familiarize themselves with the number of free and low-cost health care delivery services that are available in their communities and ensure utilization of these services to their fullest potential.

The four programs highlighted in this Spotlight demonstrate strength in linking consumers to primary care by mitigating barriers. They effectively use approaches that decrease service fragmentation and build relationships and partnerships with medical organizations, funders, and the surrounding community. While each PATH program is unique, and their approaches vary in accordance to their geographic locations and target populations, the need for connecting consumers to primary care is vital to consumer health.



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## Resources

<http://www.nhchc.org/practiceadaptations.html>

### Adapted Clinical Guidelines

National Health Care for the Homeless Council

[http://www.nap.edu/openbook.php?record\\_id=9932&page=R1](http://www.nap.edu/openbook.php?record_id=9932&page=R1)

### A Manpower Policy for Primary Health Care

Report of a Study; Institute of Medicine (1978)

[http://www.aafp.org/online/etc/medialib/aafp\\_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf](http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf)

### Medical Home Model

American Academy of Family Physicians Report (2007)

<http://fmignet.aafp.org/online/fmig/index/family-medicine/pcmh.html>

### Patient Centered Medical Home

Family Medicine Interest Group (2010)



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