Mayor's Committee on Health Reform Implementation
Subcommittee on the Health Delivery System
Minutes, Meeting of January 12, 2012

1. The Meeting was called order at 2:05 p.m. by Dr. Mohammad Akhter, the Chair of the Subcommittee.

2. Dr. Akhter opened the meeting by summarizing the following top areas of concern that were described at the most recent meeting of the Association of State and Territorial Health Officers by state officials that have responsibilities for health care delivery:
   - Expansion of Medicaid rolls, as mandated by the Affordable Care Act, which is putting heavy financial pressure on state budgets;
   - Construction of Health Insurance Exchanges, which is encountering organizational difficulties due to tight federal deadlines; and
   - Development of Innovative approaches for the control of the continuously increasing costs of health care, which is proving to be very complex.

   Dr. Akhter pointed out that the topic the Subcommittee is considering today, namely, the "Medical Home" is very germane to all three of these areas of concern.

3. The next portions of the meeting was dedicated to presentations by the following three guest experts on the topic of the Medical Home:
   - **Tina Dutta**, who is a Public Health Analyst at the Substance Abuse and Mental Health Administration and the Lead for that agency's Primary Care and Behavioral Integration Program in the Center for Mental Health Services;
   - **Amy Gibson**, who is the Chief Operation Officer of the Patient Centered Primary Care Collaborative (PCPCC); and
   - **Gary Jacobs,** who is the Senior Vice President for Corporate Development of Universal American and who also serves as Co-Chair of the Center for Public Payer Implementation, which is a component of PCPCC.

   The presentations of these experts are summarized below.

4. Summary of the Presentation by Trina Dutta

- Definitions of the "Medical Home" and the "Health Home"

  - Medical Home : An approach to providing comprehensive primary care for children, youth and adults in a health care setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patients family.

  - Health Home: An important option for providing a cost-effective, longitudinal "home" to facilitate access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions.

- The History of the Health Home

  - The term "Medical Home" was first utilized by the American Academy of Pediatrics (AAP) in 1967 to signify the single location for all of a child's medical records. The AAP expanded the definition in 2002 to expand the functions of the Medical Home to include timely access to medical services; enhanced communication between patients and their health care provider team; assured coordination and continuity of health care; and an intensive focus on quality and safety of the services provided.

  - The World Health Organization in 1978 defined "Primary Care" as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.

  - The State of North Carolina launched the precursor to its "Community Care of NC" thereby laying the foundation for a system of Medical Homes that the State implemented in subsequent years.

  - The Institute of Medicine began using the term "Medical Home" in the 1990's. The Institute defined the Medical Home as the focal point through which all individuals regardless of age, sex, race, or socioeconomic status receive their acute, chronic, and preventive medical care services.

- Wagner's Chronic Care Model was introduced in 1998. It identified the essential elements of a health care system that would encourage high quality chronic disease care as consisting of informed, activated patients; a prepared, proactive health care team; an organized health care delivery system, including an effective design, decision support and clinical information systems; and community resources and policies including support for self management of chronic diseases.

- A number of approaches to the structure and function of the Medical Home and the Health Home have been developed since 2000.

- <u>The Medical Home and the Affordable Care Act (ACA)</u>

  - Section 2703 of the ACA provides encouragement and support for the development of Medical Homes and Health Homes as a major system for the delivery of primary care. Donald Berwick, when he was the Administrator of CMS, encouraged the "The Institute for Health Improvement's Triple Aim "for Health Homes, namely, Improving the experience of care; improving the health of the population; and reducing the per capita costs of health care.

  - The Goal of ACA Section 2703 is: Enhanced integration and coordination of primary, acute, behavioral health (mental health and substance abuse), and long-term health services and supports for persons across the lifespan with chronic illness through the Health Home model.

  - CMS expects that the use of the Health Home model will result in:

    - Lower rates of emergency room use;
    - Reduction in hospital admissions and re-admissions;
    - Reduction in health care costs;
    - Less reliance on long-term care facilities; and
    - Improved experience of care and quality of care outcomes for the individual.

5. **Summary of the Presentation by Amy Gibson**

- A 2020 vision of Patient-Centered Primary Care (Commonwealth Fund 2005), includes the following 7 attributes:
  - Access to Care;
  - Patient engagement in care;
  - Information systems;
  - Care coordination;
  - Integrated and comprehensive team care;
  - Patient-centered health care surveys; and
  - Publically available information on health.

- Joint Principles of the Patient-Centered Medical Home (PCMH) as agreed upon by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association in 2007, are as follows:
  - Ongoing relationship with a personal physician;
  - Physician-directed medical practice;
  - Whole person orientation;
  - Coordinated care across the health system;
  - Emphasis on Quality and safety;
  - Enhanced access to health care services; and
  - Payment to providers that recognizes the value added by the PCMH.

- The Patient-Centered Primary Care Collaborative (PCPCC)
  - Was established in 2006; and
  - With the objective to collaborate with the primary care associations in order to:
    - Facilitate improvements in patient-physician relations, and
    - Create a more effective and efficient model of healthcare delivery.

- The PCMH as defined by the PCPCC would provide the following services:
  - Superb access to health care;
  - Patient engagement in his/her own health care;
  - Supported by robust clinical information systems;
  - Providing health care coordination;
  - Featuring delivery of services by a health care team;
  - Soliciting feedback on its services; and
  - Making health information publically available.

- PCMH Success Stories
  - Cited examples of success:
    - Vermont,
    - Maryland,
    - Minnesota,
    - New York,
    - Pennsylvania,
    - Private Sector Groups (e.g., Group Health Cooperative of Puget Sound, Geisinger Health System, Health Partners Medical Group, and Intermountain Health Care),
    - U.S. Veterans Affairs Healthcare System , and
    - U.S. Department of Defense.

- Cited Indicators of Success of the PCMH:
  - Reduction in emergency department visits;
  - Reduction in hospital admissions;
  - Lower median (or overall) costs per specific patient care group (e.g., those with chronic conditions);
  - Reduction in the costs of health care other than for emergency department visits or hospital admissions; and
  - Increased numbers of individuals receiving preventive health care services.

- General Comments
  - There is no “one size fits all model” for Medical Homes or Health Homes. The configuration of these entities will depend in large part upon local circumstances.
  - The organizational innovations associated with either of the Homes models are not likely to become fully successful without payment reform.

This reform must consist of replacing fee-for-service payments for health care services with a more comprehensive approach such as capitated payments, or value-based payments, along with reimbursement for new services such as case management and care coordination.

- The issue of financial support for the initial development a Medical Home or a Health home has not been resolved. CMS does not pay for this activity, although some State Medicaid agencies have provided such support.

6. <u>Summary of the Presentation by Gary Jacobs</u>

- A Medical Home or a Health Home probably cannot stand on its own in all settings. It appears that a Home of either type is most likely to be sustained in coordination with one or more Accountable Care Organizations.
- The fee-for-service system of payment cannot survive in the future healthcare setting. New systems of payment, particularly those connected to the quality of care, are likely to emerge as the new standard for reimbursement.
- Several of the State-based initiatives are worthy of exploration. For example, in Pennsylvania, Medical Homes collaborate with Managed Care Organizations to deliver care under a capitated payment system.
- In setting up a Medical Home or a Health Home, the initial focus could be on the individuals who generate the greatest health care costs. However, these high cost groups are not homogeneous and they should be segmented in planning for their health care.

7. <u>Summary of the Presentation by Linda Elam</u>

- CMS has issued a planning award to the DC Department of Health Care Finance in the amount of $336,000 for the development of a Health Home. Three DC Government Agencies (i.e., Departments of Health Care Finance, Department of Health and Department of Mental Health) contributed funding on an equal basis to make the $500,000 available for the planning process.
- Representatives of the three involved DC agencies meet every week to direct the planning effort.
- The decision has been made to hire a project manager to coordinate the planning effort, and to hire a consultant to develop the project plan.

- Dr. Akhter added to this presentation by pointing out that the DC project considered the following three alternative target populations for its Health Home model:
    - Those with a chronic mental illness and at least one additional chronic condition;
    - Those with a chronic HIV infection; or
    - The individuals that account for the highest cost to DC Medicaid.

8. <u>Summary of Dr. Mohammad Akhter's Comments</u>

- In developing a Medical Home or a Health Home the following four elements must be included:
    - New definitions of Primary Care that are being developed by the evolving U.S. health care delivery system;
    - The status of accountability under evolving payment system;
    - The full participation of patients in the new delivery system; and
    - The need for real time availability of data.

- In consideration of the issues raised at this meeting, the Subcommittee should address the following issues:
    - Should DC apply for additional Medical Homes or Health Homes for areas of the City that lack health care facilities and have many unmet health care needs?
    - What consideration should be given to those individuals who receive primary care from a specialist (e.g., women who receive comprehensive care from their gynecologist)?

9. **<u>Adjournment</u>:** The meeting was adjourned at 4:00 p.m.