THE CARTER CENTER

MENTAL HEALTH PROGRAM

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Proceedings of the Carter Center's Medical Home Summit

July 7th and 8th, 2009

The Carter Center Mental Health Program • Primary Care Initiative • One Copenhill • 453 Freedom Parkway • Atlanta, Georgia 30307 • (404) 420-5165

Executive Summary

As part of its efforts to assist in the scaling-up of evidence-based approaches to the more effective integration of primary care and behavioral care, the Carter Center Mental Health Program's Primary Care Initiative held a two day meeting at the Center in early July of 2009. The meeting brought together 35 thought leaders from the fields of primary care, behavioral care, and health promotion/prevention with the goal of initiating substantive discussions between the three fields about the challenges and opportunities of using the rubric of the patient—centered medical home (PCMH) as a major vehicle for fostering closer integration.

The meeting was divided into three sections. The first examined the concept of the PCMH and its role in the re-invention of and re-investment in primary care in the USA. The evidence base for the centrality of primary care in a reformed health care delivery system in the form of lower per capita costs and lower mortality rates was presented and discussed. Major challenges to the successful re-invention of primary care, such as the current focus on illness and procedures/visits in both reimbursement and training, were identified, as well as some potential solutions, such as bundled payments and complexity (rather than diagnostic) assessment were discussed.

The second session was devoted to an exploration of current efforts to integrate behavioral care into primary care. A major theme of the discussion was that time and trust are essential to the establishment of integrated care in the primary care setting, along with the recognition on the part of the payer that investment is required to make the transition from usual care to integrated care.

The final session focused on the potential transformation of the medical home into the health home. The health home would transcend the medical home by incorporating into its functions health promotion interventions at the population level as well.

In the closing plenary session, a set of action items for further consideration was developed. There was a clear consensus among the participants about the value of continuing the discussions in the future.

Overview of the Medical Home Summit

The concept of the "medical home" is gaining currency among providers and policy makers, especially among representatives of primary care specialties and organizations, and also in the context of ongoing discussions about health care reform. While still somewhat vague in all of its defining and operational characteristics, it is becoming clear that the concept of "patient-centeredness" is at its core. Yet to date, many aspects of patient-centeredness revolving around issues of behavioral conditions and the types of behavior changes required for health management and prevention—as opposed to illness management—remain to be addressed in the ongoing discussions around the patient-centered medical home (PCMH).

In order to initiate and facilitate discussion around these issues and to foster collaboration between the three fields of primary care, behavioral health care, and health promotion/prevention, a meeting was convened July 7 – 8, 2009 at The Carter Center in Atlanta, Georgia. The meeting brought together approximately 35 thought leaders from the three fields. The summit was divided into three main sessions, each with a distinct focus in the context of the overarching goals for the meeting:

- to facilitate discussion on the integration of behavioral health care into the medical home and to identify next steps based on the outcome of those discussions;
- to initiate discussions about the approach to health promotion and prevention in the PCMH and to generate action items from these discussions; and
- to explore the feasibility of positioning the medical home as the primary location for prevention/health promotion and to identify ongoing activities required to transform the medical home to the health home.

An underlying goal was to come up with concrete action steps for the future, including but not limited to a featured place on the agenda of the 25th annual Rosalynn Carter Symposium on Mental Health Policy, which took place Nov. 5-6, 2009, at the Center. In addition, another underlying goal was to impact ongoing discussions in Congress as it considers health care reform legislation on behalf of the tens of millions of individuals dealing with behavioral health issues such as depression, anxiety, and substance abuse who receive care exclusively in the primary care sector.

July 7th

Session One: "Building the Patient Centered Medical Home: Challenges and Opportunities under Health Care Reform"

The first session provided an overview of the concept of the patient-centered medical home and explored the challenges and opportunities arising from current efforts at implementation of the medical home in primary care. **Rich Roberts**, M.D. (president-elect, **World Federation of Family Doctors)** began the session by reviewing the evidence base for the establishment of a strong and robust primary care sector as the center of any effective and efficient health care delivery system with its facilitation of the building of trusted relationships between patients and physician-led health care teams.

Current obstacles to the establishment of the PCMH in the United States were addressed by **Larry Green**, M.D. **(University of Colorado)**, which included defining the current system as a "wealth care" system focused on the reimbursement of illness-focused procedures and services, rather than on health outcomes and patient experience. He emphasized the importance of changing the current health education efforts to better emphasize the skills and knowledge required to work in the PCMH.

Linda Rosenberg, M.S.W. (president and CEO, **National Council for Community Behavioral Healthcare)** reviewed the political climate surrounding the current efforts at health care reform and predicted that the final result of this round of health reform would be to settle for increased access rather than for true delivery system reform. She did agree that there was a clear movement in policy circles toward giving primary care a central role in any reformed health delivery system. Her organization is focusing its resources on the establishment of medical homes for people suffering with severe mental illnesses through collaborative efforts between community mental health centers and federally qualified health centers in 20 locations around the country.

The importance of community involvement and assessing the complexity of patients' lives (rather than simple diagnosis) was emphasized by **Mac Baird**, M.D., M.S. **(University of Minnesota)**. Dr. Baird emphasized that as the health care delivery system fragments into smaller and smaller areas of expertise, the result is technical proficiency rather than true health. Different funding arrangements, such as capitation or bundled payments are necessary to adequately fund the evaluation of the whole patient and the establishment of a trusted relationship.

The general discussion following the presentations focused on a relatively small number of themes. These included the following:

- The need for system reform, with an increased investment in primary care.
- The importance of payment reform, with movement away from fee-for-service and a focus on efficiency toward payment schemes that reward relationship-building and effectiveness.
- The centrality of a trusted relationship between a physician-led health care team and the patient to both control cost and increase quality and effectiveness.
- The ending of the artificial separation of mind and body that exists under current structures and approaches.

There was much discussion about the need for payment reform as a foundation for a reformed health delivery system capable of supporting and implementing the patient-centered medical home concept. Much of the discussion supported the importance of transitioning from a payment system that rewards only procedures and face-to-face visits to one that supported the establishment of an ongoing and trusted relationship with a physician and associated health team, a relationship that played out over multiple means of communication. The patient-centered medical home and its emphasis on the relationship between the patient and the physician/health care team were supported as the primary means of controlling costs and advancing quality. Comments were made in support of both "bundled" payments and capitation as ways of reimbursing for relationship-building, with no decision made as to which, if either, was superior. There was, however, some disagreement about the wisdom of payment reform preceding system redesign, with strong support from the majority of the group for the wisdom of developing a common vision of a redesigned, primary care-driven delivery system to guide efforts at payment reforms.

Session Two: Moving Behavioral Care into the Medical Home: Operational and Policy Challenges and Opportunities

The second session addressed the challenges and opportunities for integrating primary care and behavioral care under the rubric of the patient-centered medical home concept. **Hyong Un**, M.D. (national medical director/behavioral health, **Aetna Health Plans)** described his organization's efforts to support primary care physicians in the management of behavioral health conditions in their practices. Sixty percent of behavioral healthcare within Aetna is done in the primary care setting. Time and trust are essential to the establishment of integrated care in the primary care setting, along with the recognition on the part of the payer that investment is required to make the transition from usual care to integrated care.

Wayne Cannon, M.D. (primary care clinical program leader, **Intermountain Healthcare)** explained that the integration model used at Intermountain Healthcare was about primary care and that all resources were used to support primary care physicians working with families. The Intermountain model provides a common toolkit for evaluation, diagnosis, and follow-up care along with on-site mental health specialty consultation. Other aspects of the model include: care management, a stratification model for resource allocation, electronic medical record communication (message log and progress notes), family support and engagement, and evaluation

and data reporting. Based on this model, Intermountain data show significant decreases under integrated care in such areas as ER visits, inpatient admissions, and length of stays, as well as improvements in patient and physician satisfaction.

The special needs of the safety net population (i.e., Medicaid, Medicare, and the uninsured) were addressed by **Barbara Mauer**, M.S.W. (managing consultant, **MCPP Healthcare Consulting, Inc**). Ms. Mauer emphasized that removing many of the barriers commonly identified (finance, regulation, sharing of information, etc.), all of which were addressed in a recent Seattle demonstration, did not remove the cultural differences, historic lack of trust, or the challenges of implementing evidence-based practices in the primary care setting.

Nico Pronk, Ph.D. (vice president and health science officer, **Journey Well)** addressed the question "What is the value of prevention/health promotion?" He pointed out that addressing the social determinants of health might be a more cost-effective strategy than investing in health care services for reducing disease burden on a population basis over time. There is strong evidence for the effectiveness of physician-led or sponsored preventive interventions. Dr. Pronk supported the promise of technology, such as Web-based educational and self-monitoring tools, within the context of the trusted relationship with a primary care physician-led health team.

Once again, the discussion focused on a small number of themes. One was the importance of information technology to the integration of primary care, behavioral care, and even health promotion prevention. This importance is based on two major functions: the ability to facilitate communication and coordination of care and the ability to establish priorities based on data (for example, through the establishment of patient registries).

The discussion then focused on strategies for improving communication and coordination between primary care physicians and specialty providers, either from the behavioral health care or the health promotion/prevention areas, with particular emphasis on efforts to coordinate with small primary care practices (as opposed to large integrated groups such as Intermountain or Group Health).

The discussion moved to the importance of the PCMH's emphasizing not just more coordinated care for illnesses, but also focusing on the population health status of its members. The PCMH can, through the aggregation and analysis of individual patient data, help to prioritize and direct population and community-level interventions.

This discussion led to an exchange concerning the possibility of using the PCMH as a common platform for managing all chronic illnesses, medical, behavioral, as well as health risk factors. At the clinical level, the use within the PCMH of complexity assessments of individual patients, in addition to the more traditional diagnostic assessment, was supported. Complexity assessment, because it looks at illness as well as social supports, can be used to generate linkages between the PCMH and the greater community, including the family and the workplace.

In the end, the participants agreed that the PCMH movement must absolutely make room for both behavioral care and health promotion/prevention within the PCMH. In fact, the PCMH should be seen as the common platform for managing chronic conditions, both medical and behavioral, as well as a variety of health risk factors at the individual and even community level.

Building a Culture of Health

The dinner speaker was **Peter Wald**, M.D. (assistant vice president for Wellness, **USAA**). Dr. Wald began by describing the origins of the Wellness Program that he currently leads at USAA. Through the program, USAA is building a "culture of health" as its primary health care strategy, and the program, itself, represents an exemplary model of applied public health that includes educating and incenting employees and their dependents toward healthier lifestyles. Dr. Wald's recommendations about the inclusion of health promotion/prevention in the medical home included: first dollar coverage of evidence-based prevention practices, establishing universal health risk assessments and biometric screening, requiring all plans/plan sponsors to deliver wellness and behavioral risk reduction programs, measuring screening participation and risk reduction results, and integrating all preventive and medical care with an electronic medical record.

July 8th

Session Three: "Making Room for Health Promotion and Prevention in the Medical Home"

David Grossman, M.D., M.P.H. (medical director/preventive care, **Group Health**) focused on the clinical aspects of prevention and the strategic importance of the integration of prevention and health promotion with the chronic care model to establish "planned care." He focused on the challenges faced in realizing this integration, which include health care access and finance, integration of prevention with chronic care, the effectiveness and cost-effectiveness of preventive services, managing information, defining roles of the clinical team to deliver preventive services, and linkage to external community-based services.

The importance of including prevention and promotion in the medical home was discussed by **Terri McInnis**, M.D., M.P.H. (medical director/health policy and advocacy, **GlaxoSmithKline**). All increases in health care costs cannot be attributed just to the delivery system, but also reflect the decreased health status of our population. The value of secondary and tertiary prevention is currently recognized, but work is needed on including primary prevention as well.

Ron Manderscheid, Ph.D. (mental health and substance abuse programs, **SRA International, Inc.**) focused on the transformation of the medical home into the health home. The health home would serve as a health promotion organization with a full range of activities from prevention to treatment. The health home would transcend the medical home by incorporating into its functions health promotion interventions at the population level as well. One way of potentially funding these additional functions could be the adoption of some form of population health insurance that would provide resources and staffing (e.g., population health coaches) to pay for the improvement of population health status.

The damaging trend of focusing on efficiency at the expense of effectiveness was addressed by **Ray Fabius**, M.D., F.A.A.P. (strategic advisor to the president, take care health, **Walgreen's Health and Fitness**). Dr. Fabius promoted the notion that we need "trusting relationships" to increase compliance with health promotion/preventive interventions.

The discussion following the presentations focused at first on the linkages between the health home and the community. The Healthy People program was mentioned as a vehicle for providing guidelines and benchmarks for population-based programs within the PCMH. There also was support for the concept of linking population health insurance to community ratings, with those communities with a higher rating receiving a higher population health insurance component in order to lower community risk over time.

Another discussion point focused on education and training. Panelists discussed worry over the lack of prevention and health promotion training within healthcare education and the necessity for a student to pursue extra training to understand the medical home.

Several participants reinforced the idea that patient-centered medical home training needs to become part of medical school and residency programs (it is becoming an integral part of many of the primary care specialties).

Closing Plenary Discussion

The closing discussion focused on two major areas: the first of these was the need to formulate action steps, both in the long- and short-term; the second was the need for an ongoing convening body to facilitate and coordinate continued discussions among the three fields represented at the Medical Home Summit. Identified potential action items included the following:

- the explicit inclusion of requirements for evidence-based approaches to integrated primary/behavioral care within all PCMH demonstration projects;

- the review of the current Joint Guidelines for Demonstration Projects to include behavioral care and health promotion/prevention;

- the immediate need for legislative language supporting evidence-based approaches to integrated care for inclusion in one or more of the various health reform bills under development in Congress;

- the need for comparative case studies to identify best practices in integrated care and the call for professional journals to support their publication;

- the need to examine current approaches to privacy regulations and legislation to support appropriate communication and coordination of care across multi-disciplinary teams;

- the need to transform medical/health education to better train the students of today to function optimally in the reformed health care delivery system of tomorrow, with (hopefully) a renewed investment in primary care and a new investment in health promotion/prevention;

- the facilitation of major presentations at all primary care specialty meetings re: the importance of integrating behavioral health care and health promotion/prevention into the PCMH;

- the need to involve young leaders from the three fields in all ongoing discussions;

- the development of a strong, simple message supported by summit attendees that emphasizes the importance of building behavioral care and health promotion/prevention activities into the PCMH; and

- the continuation of a convening authority, most likely through The Carter Center, to continue discussions and to monitor progress against specific objectives and deliverables.

Attendees

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Key Facts on the Medical Home Debate

What is a medical home?

- Under the medical home model, the patient is supported by a team of health care professionals who share responsibility for the patient's health. Medical homes can strengthen the primary care system by replacing poorly coordinated, illness-focused, and episodic care with a coordinated primary care-led delivery system that focuses on the whole person, not just on their illness (Adams et al, IBM Institute for Business Value).

- **Fourty-four** states and the District of Columbia have passed or introduced at least **330** laws to define or demonstrate the medical home concept (Patient Centered Medical Home Collaborative).

Why is a medical home important to health reform? Why is it important for health promotion?

- If successful, the medical home system could **help Medicare remain financially viable** as the baby boomer population ages (Jane Brody, New York Times).

- Community Care of North Carolina saved **$161 million** per year by implementing a medical home model (Beat et al, Annals of Family Medicine).

- The Voice of Detroit Initiative, a medical home pilot study, reduced emergency department use by more than **60 percent** and cut uncompensated care costs from $51.2 million to $29.7 million (Adams et al, IBM Institute for Business Value).

How do medical homes impact the patient?

- Only **65 percent** of U.S. adults under age 65 have access to a primary care physician and **half of adults** say their care is not coordinated, with specialists not receiving information from primary care providers or never being called about test results (Commonwealth Fund).

- People who live in states with higher ratios of primary care physicians to patients are less likely to die from cancer, heart disease, or stroke (Adams et al, IBM Institute for Business Value).

What role do medical homes have in current health reform legislation and policy?

- Health and Human Services Secretary Kathleen Sibelius and White House Office of Health Reform Director Nancy-Anne De Parle have publicly supported medical homes as part of health reform (AAFP, Kaiser Family Foundation).

About the Carter Center's Mental Health Program

Founded by former First Lady Rosalynn Carter in 1991, the Carter Center's Mental Health Program works to raise awareness about mental health issues and combat stigma and discrimination against people with mental illnesses. The Carter Center's Mental Health Program launched the Primary Care Initiative (PCI) in 2008 as a two-year project to increase the early detection and treatment of depression, anxiety, and substance abuse in primary care settings.

For more information on the Primary Care Initiative, mental health references, or reports, please visit the Mental Health Program Web site:
http://www.cartercenter.com/health/mental_health

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