



buyers health care action group
BHCAG

eValue8 Community Forum Health Care Home

July 16, 2009



eValue8 Community Forums Community Forums grow out of the BHCAG sponsorship of the National Business Coalition on Health's eValue8 RFI. eValue8 is the result of coalition and purchaser member efforts to standardize specification and performance criteria for health care plans. Every year Minnesota health plans are invited to complete the eValue8 RFI. BHCAG uses information from eValue8 results to identify community-wide improvement opportunities and hold forums around these opportunities. Each participating plan is invited to host a forum where groups educate and inform one another about an issue, discuss potential solutions and determine how health plans, employers and providers can collaborate across the market to improve care.

Community Forum on Health Care

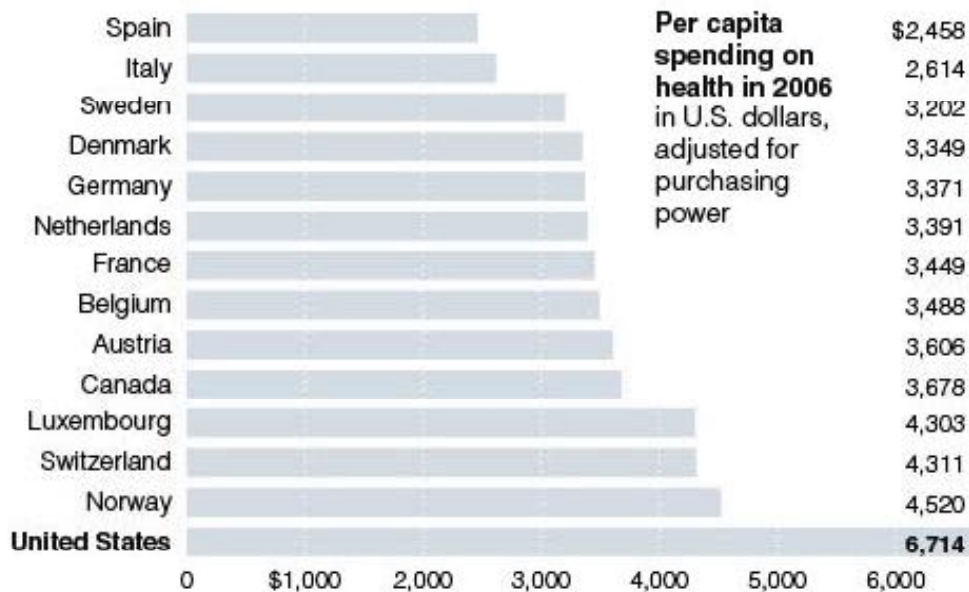
The Community Forum on Health Care Home took place on July 16, 2009. It was hosted by Blue Cross Blue Shield of Minnesota with support from the Buyers Health Care Action Group, HealthPartners, Medica and PreferredOne. Speakers from various stakeholder groups shared their perspectives on developing and supporting the concept of a health care home. These speakers included:

- Anshu Choudhri, Blue Cross and Blue Shield Association
- Dr. Jeffrey Schiff, Minnesota Department of Health and Human Services
- Valerie Overton, Fairview Health Services
- Robert Van Why, HealthPartners

Anshu Choudhri, Blue Cross and Blue Shield Association

Mr. Choudhri began his presentation by giving a summary of where the U.S. health care system ranks when compared with other industrialized nations. The U.S. spends the most among industrialized nations on health care, but its quality of care ranks among the lowest. One of the reasons health care costs in the U.S. are high is because the biggest consumers of health care are those with complex, acute and chronic conditions.

Mr. Choudhri noted that countries with a strong focus on primary care and prevention, such as



Department of Health and Human Services; Organization for Economic Cooperation and Development

THE NEW YORK TIMES

Denmark, have higher quality and lower cost health care than the U.S. He suggested that this primary care approach would be beneficial in the U.S.

The health care home, or medical home, model was developed in the 1960s but is continuing to evolve in its definition and scope. The main aim of the health care home is to change the way primary care is delivered by providing a central point through which a patient can navigate care. It shifts payments to doctors away from volume-based pay (fee for service) to payments for care coordination, patient and specialist follow-up and health outcomes. It also requires an investment in technology so that primary care physicians are able to coordinate care accurately and efficiently.

Mr. Choudhri presented the results of two demonstrations that show both reduced costs and improved care for patients within a health care home setting. More demonstrations are underway, and it will take time to evaluate their effectiveness. Initial results show that the health care home provides benefits for all stakeholders.

- Patients are given more resources with which to make their health care decisions, they are empowered with a better physician/patient relationship and they achieve healthier outcomes.

- Clinicians are better supported by plans to achieve healthy outcomes and they are compensated for providing preventive services.
- Employers are able to purchase health care based on value, and their employees are healthier and more productive.

The future of health care homes will depend on delivering value as well as on successful innovation and implementation. Because the concept of a health care home is still in the evaluation stage, the best way for purchasers to participate at this point is to stay informed on the debate and pay attention to the results of demonstrations. Stakeholders can also get involved in pilot programs, integrate health care home strategies and engage consumers in the concept. To view Mr. Choudhri's presentation, please click [here](#).

Dr. Jeff Schiff, Medical Director, Minnesota Department of Health and Human Services

Dr. Schiff presented an overview of how the state has been involved in analyzing and supporting the health care home. In 2003, the state implemented a pilot pediatric health care home with 7000 children. The results were a reduction in hospitalizations and emergency room visits as well as an increase in patient satisfaction. In 2007, Minnesota passed the first health care home legislation directed at patients within the Medicaid fee-for-service population with complex illnesses. Last year, the state passed legislation that requires health care homes for all Medicaid and SCHIP enrollees, state employees and privately insured Minnesotans.

When defining a health care home, the state identified the following criteria:

Access and Communication: There must be 24/7 access and patients must be able to speak to someone with knowledge of their medical history.

Care Coordination: Patients with coordinated care achieve better health outcomes. When possible, there should be co-location of the primary care provider and a care coordinator.

Care Plans: Individual plans should be created for complex patients.

Registry: There should be registry systems that allow providers to manage their population.

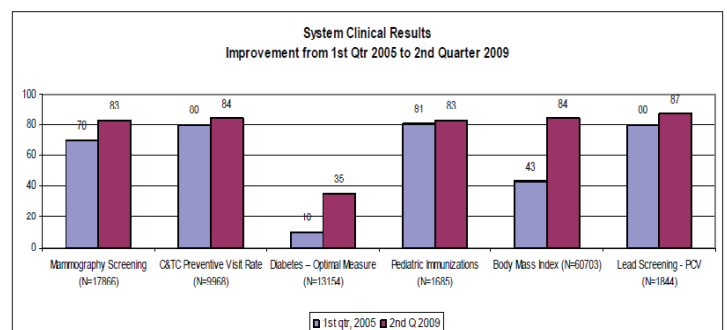
Quality Improvement Program: Patients should be included on committees that offer ideas on quality improvement.

The State of Minnesota is working on a certification process through which providers can be identified as a health care home. Both clinics and individual providers will be able to apply for health care home status. Dr. Schiff also noted that the health care home provides benefits to all stakeholders. With care coordination, patients will not need to run interference in order to get the care they need. Primary care providers will have new payment streams, specialists will receive fewer requests for unnecessary services and plans and employers will get the most out of the system, therefore decreasing health care utilization downstream. For Dr. Schiff's presentation, please click [here](#).

Bob Van Why, HealthPartners

Mr. Van Why described the systemic approach HealthPartners has taken in regard to the health care home. Rather than focus on a payment source or particular disease to determine a population, HealthPartners has applied the health care home concept throughout its entire network. According to Mr. Van Why, one of the main goals of the health care home should be to improve population health one patient at a time. Health care homes should also increase the sustainability of primary care as these positions are increasingly difficult to fulfill.

Mr. Van Why identified three characteristics for successful health care homes. They should be designed to meet individual needs and preferences of the patients. They should also be delivered by multidisciplinary teams and coordinated with other providers and health plan services. HealthPartners has been developing a health care home model with these characteristics since 2004, and the results of its efforts are seen in the chart below:



HealthPartners has received tier three level Medical Home recognition from the National Committee for Quality Assurance (NCQA). They are the only medical group in Minnesota, and the only medical group of its size in the nation, to receive this designation. The next steps for HealthPartners include assessing its current performance compared to NCQA Medical Home criteria and understanding its current resources.

HealthPartners recently conducted a Medical Home Diagnostic study that measured workflows by task and time. The goal of the study was to look for opportunities to better define and streamline roles by revealing where excess capacity exists. The results of the study showed that some of the work being done by physicians could be transferred to other clinic staff. HealthPartners can use these studies to identify ways to make the health care home more effective. It is focusing on four specific areas to further develop the health care home concept throughout its system:

1. Identification of a primary care physician's patient population (i.e. who are physicians responsible for)
2. Development of a comprehensive patient registry
3. Increased coordination of care from the hospital to the home – post-visit and in-between visit will be emphasized
4. Engagement of patients in their own health

To view Mr. Van Why's presentation, please click [here](#).

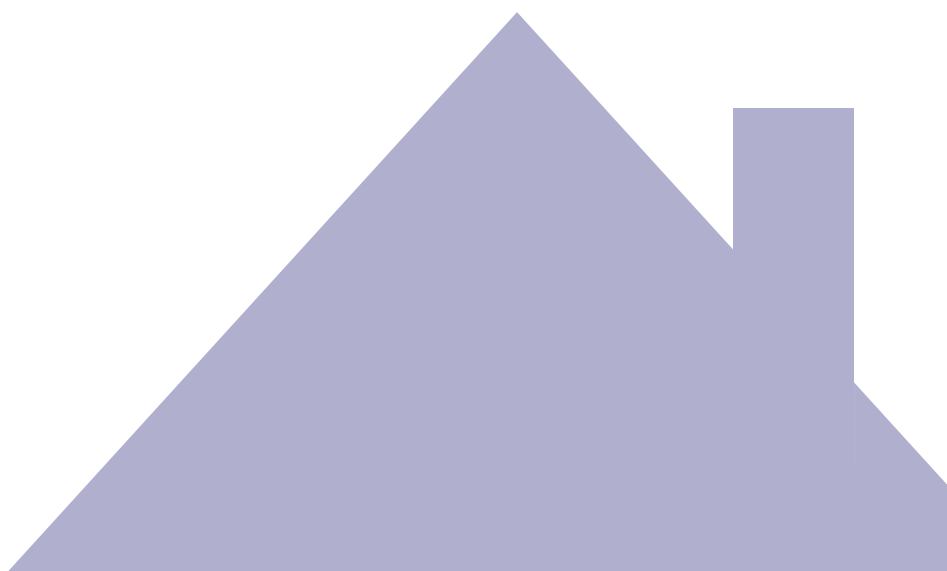
Valerie Overton, Nurse Practitioner, Fairview Health Services, Eagan Clinic

Fairview Health Services has embarked on a care redesign initiative, with the Fairview Eagan Clinic one of the facilities participating in the initiative. The overarching goals of the redesign are:

1. Decrease total cost of care
2. Increase panel size
3. Improve ambulatory optimal care
4. Increase patient satisfaction

At Fairview's Eagan Clinic, staff are focusing on leadership training in order to achieve a new model of care. Ms. Overton maintained that physicians are trained to lead technical work but not to manage complex cultural change. Therefore, Fairview's Eagan Clinic is establishing a new value chain, placing people in various roles on "teamlets" that work together to solve problems. These teamlets meet regularly to discuss work flow and best practices, and they are creating goals to cut costs and improve quality of care. The work of each teamlet is measured, and results are distributed to all teamlets for comparison. The clinic also established a blog where individual staff members can contribute ideas on solving problems.

Ms. Overton described a "new world" of health care and emphasized the need for providers to adapt quickly by investing in leadership training for all staff members. To view Ms. Overton's presentation, please click [here](#).



Discussion Panel

Following the presentations, audience members asked questions of the panel including:

When thinking about disease management programs, where are the boundaries between plan and provider?

The panelists noted that the further you get from the patient/primary care provider relationship, the lower the ROI of disease management programs. Therefore, plans should think about investing in models within the primary care setting instead of developing separate disease management programs.

What are the lessons from successful demonstrations that can be applied when developing health care home models?

Demonstrations tend to be more successful and move more quickly when supportive state infrastructure has been established. Multi-stakeholder demonstrations, while more difficult to get up and running, seem to be more sustainable in the long-run.

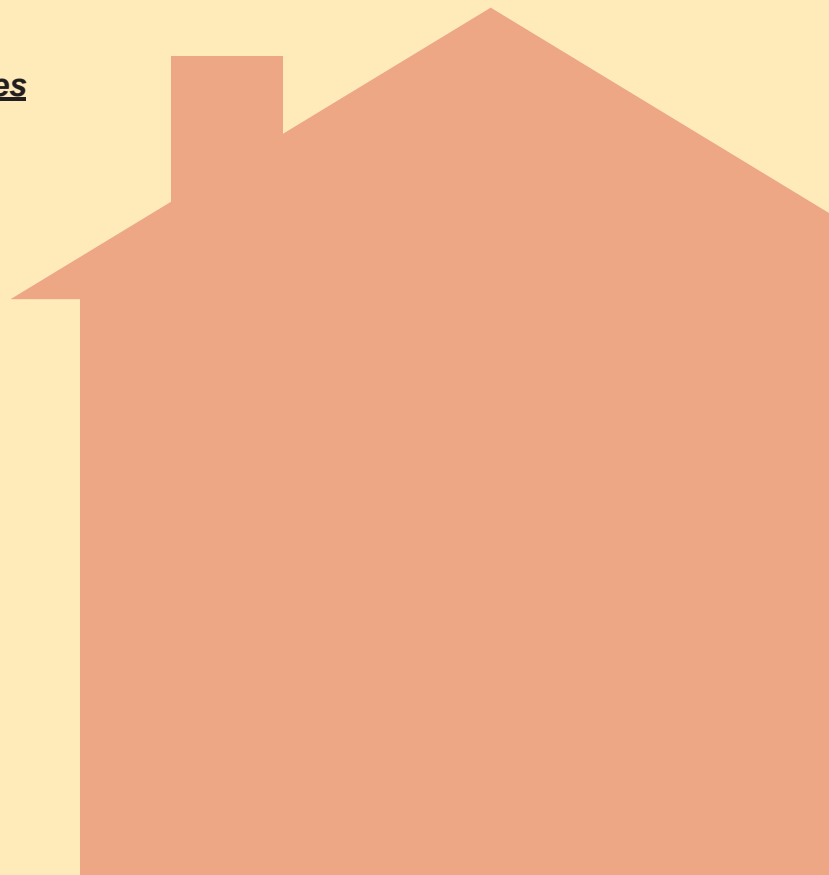
How are hospitals reacting to the idea of a health care home since it may decrease their revenues?

More progressive hospitals look at themselves as an integrated delivery system; they are connected to the entire network of care. In a diversified group such as HealthPartners, everyone is responsible for the total cost of care, so hospitals should view the health care home from this perspective.

Additional Resources

Minnesota Department of Health Website

Blue Cross Blue Shield Medical Home Initiatives





To view this paper online and access all of the presentations, visit www.bhcag.com in the eValue8 section under Driving Value.



buyers health care action group

BHCAG

7900 International Drive, Suite 1080
Bloomington, MN 55425
952-896-5186
www.bhcag.com