Proceedings of the Carter Center's Medical Home Summit

July 7th and 8th, 2009

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 th

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

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.

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. , M.D. (national medical director/behavioral health,) 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.

, M.D. (primary care clinical program leader,) 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

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.

The dinner speaker was , M.D. (assistant vice president for Wellness,). 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.

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).

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

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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

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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