

Health Reform: New Models of Care Workgroup
Wednesday, October 20, 2010
North Carolina Institute of Medicine, Morrisville
1:00pm-4:00pm
Meeting Summary

Workgroup Members: Allen Dobson (co-chair), Deborah Ainsworth, Randall Best, Don Bradley, Judy Brunger, Peter Chauncey, Chris Collins, Tracy Colvard, Linda Cronenwett, Analiese Dolph, Nena Lekwauwa, Beth Lovette, Beth Melcher, Renee Rizzutti, Valinda Rutledge, Allen Smart, Brenda Sparks, Robert Spencer, Gina Upchurch, Torlen Wade, Jack Walker, Jennifer Wehe, Susan Yaggy

Steering Committee Members: Allen Feezor

NCIOM Staff: Thalia Fuller, Pam Silberman, Rachel Williams

Other Interested Persons: Kari Barsness, Aaron Beck, Marie Britt, Rebecca Carina, Steve Cline, John Dervin, Lee Dixon, Tara Larson, Ann Lore, Linda Lockhart, Michelle Lyn, Karen Maynard, Gary Massey, Catherine Moore, Jennifer Nelson-Weaver, Lydia Newman, Melanie Phelps, Lendy Pridgen, Tom Ricketts, Lisa Rowe, Chris Skowronek, Denise Thomas, Elizabeth Walker, Judy Walton, Andrew Weniger, Jean Wester, Rebecca Whitaker

Welcome and Introductions

Allen Dobson, MD, FAAFP

Vice President, Clinical Practice Development

Carolinas HealthCare System

Co-Chair

Dr. Dobson welcomed the group and everyone introduced themselves. He then gave a brief review of what the group has been charged to do.

Patterns of Patient Health Care Seeking

Tom Ricketts, PhD

Deputy Director for Policy Analysis

Cecil G. Sheps Center for Health Services Research

Dr. Ricketts gave a presentation comparing North Carolina healthcare utilization statistics with current AHEC regions, emergency network regions, and primary care service areas. The utilization information could be useful in determining new ACOs. His presentation can be found here: [NC Patterns of Healthcare Seeking](#).

Selected questions/comments:

- Q: What challenges would hospitals that are close together (i.e. Wake, Duke and UNC-CH) have in creating an ACO? A: There would be a lot of competition; however, there are also areas of local dominance (i.e. Duke is dominant in Durham).
 - Comment: In dominant areas it would be useful for large hospitals to be involved in ACOs.
- Comment: As doctors move, especially specialists, utilization structures change because patients tend to follow a trusted doctor.
- Comment: Looking at maps devoted to resources such as hospitals is not the best way to design what we want. Also, specialty medical care, such as cancer and heart disease, has a very different patient pattern than that of primary care. We need to focus on more of a primary care ACO model that extends into other regions.
- Comment: All healthcare is supposed to be centered around the patient, not an institution or provider. These maps show that patients are mobile and are not homogeneous. Having bundled payments for specific and identifiable services can be a gateway into thinking about ACOs.
 - Response: A concern about bundled payments is trying to bundle discrete bundles of care when it's really about coordination of care. 80% of Medicare cost is related to patients with four or more chronic diseases.

Illustrative Examples of New Models in North Carolina

Bridges to Health

Aaron Beck, MD

Pardee Flat Rock Family Health Center

Henderson, NC

Dr. Beck gave a presentation about the Flat Rock Advanced Medical Home Project via teleconference. The project is a part of the P4 (Preparing the Personal Physician for Practice) Residency Demonstration Initiative. The Flat Rock facility uses an integrated care model and technology to better serve its patients. His presentation can be found here: [The Advanced Rural PCMH](#).

Selected questions/comments:

- Q: What's the total number of patients the facility has? A: About 400 and growing.
- Q: Is there a large Hispanic population where you are, and if so, are language barriers a problem? A: There is a large Hispanic population here and we are working on getting more bilingual clinicians. Right now we only have 2 Spanish-speaking providers. We are also working on translating our website so Spanish-speakers will be able to use that as well.

- Q: Do you have any difficulty having big payers covering e-visits? A: Not that I am aware of. There are not very many e-visits to begin with because patients would rather come in and see a doctor in person.

Integrative Behavioral Health in Patient Centered Medical Homes

Karen Maynard, MSW, LCSW, LCAS

Director of Behavioral Health

Guilford Child Health, Inc.

Guilford Adult Health

Ms. Maynard gave an overview of how Guilford Health integrates primary care and behavioral health. Patients are more likely to accept behavioral health services that are provided as part of a primary care visit. Integrating behavioral health in the primary care setting helps reduce see the stigma of seeking or receiving behavioral health services. Her presentation can be found here:

[Integrated Healthcare.](#)

Group Health Visits

Lydia Newman

Access III of Lower Cape Fear

Ms. Newman explained how Access III of the Lower Cape Fear uses group medical visits to improve quality and efficiency. Group medical visits are successful at bringing in patients with chronic conditions and at decreasing costs while improving care. Her presentation can be found here: [Group Medical Visits.](#)

Independence at Home

Michelle J. Lyn, MBA, MHA

Assistant Professor

Chief, Division of Community Health

Department of Community and Family Medicine

Associate Director, Duke Center for Community Research

Duke University Medical Center

Ms. Lyn outlined the Just for Us (JFU) program. This program helps seniors live independently for as long as possible. JFU uses a PACE (Programs of All-inclusive Care for the Elderly) model to provide case management and primary care to its patients in their homes. Her presentation can be found here: [Just for Us.](#)

Selected questions/comments from previous three presentations:

- Q: Ms. Newman and Ms. Lyn, did you use a control group for your data or is the data from the same group over time?
 - Lyn: We looked at claims-based data over time so there was no control group.
 - Newman: We compared our group medical visit data to usual care, or individual visit, data.
- Q: Ms. Newman, are there any barriers to expanding the use of group medical visits? A: It is hard to implement group medical visits in current practices because everything is structured on an individual care model. Implementing group visits takes a lot of thinking and time. There are also issues with convincing providers that group medical visits are covered by payers and that visits are in compliance with HIPAA. Also, once a practice has started group visits if the doctor or nurse who championed them leaves, the practice does not usually continue offering them.
- Comment: Common elements in all three of these models have to do with facility space and costs of space. It is probably worth a look at alternative facilities for community and school based clinics to save costs.
- Q: Ms. Lyn, how would you duplicate your model in a rural area where need is great and patients are spread out? A: Part of it is figuring out what makes sense in people's lives. To take a traditional facility and adapt it in any setting requires you to find a focal point and build around it.
 - Comment: You can expand the model beyond using a housing authority. The key is to find a way to provide home visits without a lot of drive time.
- Q: All three models want care management among larger social issues. Are you able to provide it?
 - Newman: Yes, we provide care managers at our practice.
 - Lyn: Yes.
 - Maynard: Yes, our care managers are employees of the clinic and are available to all patients.
- Q: Ms. Newman, have you tried groups focused on remedial health? A: Yes, we have tried remedial health with teen moms; however, they complained about the time requirements for participation but that could have been because the group was with adolescents.

Workgroup Discussion

The ACA creates a new Center for Medicare and Medicaid Innovation and identifies new models of care that are to be tested for quality and cost (Sec. 3021). The Secretary is also charged with establishing other options or demonstrations that improve quality and reduce costs to Medicaid or Medicare. Dr. Silberman presented a handout that describes the different options envisioned in the ACA, along with some of the corresponding initiatives that have been or are being tested

in North Carolina. A copy of Dr. Silberman's presentation can be found here: [New Models—North Carolina Inventory](#).

The workgroup was asked what kind of infrastructure North Carolina needs in order to support these programs? And what other Medicaid demonstration opportunities the state may want to consider on a statewide basis?

Infrastructure needed:

- Before undergoing any new initiative, we need to define success measures, and how we are going to evaluate the new initiative. What are we trying to accomplish?
 - Costs (medical expenses per person)
 - Improving health metric/process, outcomes
 - Improving access to care, transitions/coordination
 - Unnecessary care, mishandled coordination
 - Is it scalable? Can it be duplicated?
- Real-time data
- IT infrastructure that can link different IT systems
- Understanding and support for new business models
 - Translate, transformation, transition
- Data repository for payer information that is patient-specific
- We need to distribute information about the success and failures of past demonstration efforts
- Knowledgeable resources
- Multi-payer initiatives

Before deciding on what models we may want to consider on a statewide basis, we need to know what problems we are trying to address. Dr. Silberman noted that national data suggest that North Carolina has more rapidly increasing health care costs than the national average. North Carolina also does not fare well in comparisons with other states on health outcomes, or health system measures.

The workgroup began to discuss different options for new models. For example, if the state wanted to address costs, it might want to consider models that use less highly trained health professionals in different ways (ie, allowing health professionals to practice to the full extent of their training and competency). Workgroup members also discussed the need to develop patient-centered and community-centric care rather than hospital-centric care.