Iowa Collaborative Safety Net Provider Network

October 9, 2007

Senator Jack Hatch, Co-Chair
Representative Ro Foege, Co-Chair
Legislative Commission on Affordable Health Care Plans for Small Businesses and Families
Iowa State Capitol
Des Moines, IA 50319

The Honorable Sen. Hatch and Rep. Foege:

On behalf of the Advisory Group to the Iowa Collaborative Safety Net Provider Network (Network), I am sending you this statement on medical home developed by the Network for the Commission's consideration.

House File 909 established the Commission on Affordable Health Care and expanded partnerships and funding for the Network. The concept of medical home was prevalent throughout the legislative language in the Network portion of the bill, and funding for Network partners was tied to "assisting patients in determining an appropriate medical home."

Given the interest by the Iowa General Assembly in ensuring the safety net focuses attention on medical home, the Advisory Group to the Network has prepared this statement on medical home for the Commission members to consider as integral to their deliberations as well.

It is our hope that the concepts on medical home in the enclosed statement will help inform your important work.

Thank you for your consideration of this information.

Sincerely,

Christopher Atchison, Chair
Network Advisory Group

THE *MEDICAL HOME* CONCEPT

A policy imperative to guide Iowa's healthcare reform

House File 909 created the Commission on Affordable Health Care that is exploring ways to expand access to care to Iowa's current uninsured populations. HF 909 also expanded financial support to the Iowa Collaborative Safety Net Provider Network (Network) by providing funding initiatives for a variety of Iowa's safety net providers. The Network would like to pass on to the Commission the following comments regarding *medical homes*.

We wish to point out that *medical home* is a unifying policy theme embodied in the language throughout the portion of HF 909 that funds our Network. The language consistently states that money is provided, "to assist patients in determining an appropriate *medical home*." To that end, the Network has engaged our partners in a conversation to more fully develop an understanding of the history of the concept and to develop a definition/vision of how there could be life breathed into the concept. The following is the product of that work.

The concept of *medical home*[1] has gained considerable momentum since first being proposed by the American Academy of Pediatrics in 1967. It is now endorsed with some variations by the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association, among others. Though it can be related directly to funding issues, *medical home* is first and foremost a conceptual quality of care framework, recommending how basic healthcare should be provided and how the overall system should be organized.

A ***medical home*** encompasses the following characteristics. It is *accessible* in that patients are not challenged by geography, culture, language, or cost in receiving services. It is *continuous* in that patient and healthcare professionals have an ongoing relationship. That relationship is *compassionate* in that it recognizes the unique characteristics and needs, including *culture*, of each individual. It is *comprehensive* by providing access to all needed healthcare services. This does not mean that any one professional or even organization provides all aspects of care, but that the responsible medical home professionals can serve as a coordinated entry point to all needed services. A medical home is provided whenever appropriate in the context of *family*. The care will be delivered *effectively and with quality,* including incorporation of the patient's perspective. This latter perspective requires that patients be *educated and empowered* so that they may more effectively self-manage their care, where appropriate.

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[1] "*Medical home*" is intended to encompass medical care, mental health care and oral health care.

The first characteristic of a *medical home*, *access* to health care, is also the most fundamental. Gathering data on Iowans who have a medical home is challenging, especially for the uninsured for whom we have so little data in general. However, we gain some insights from the Behavioral Risk Factor Surveillance System (BRFSS) survey that is conducted annually by the Iowa Department of Public Health Bureau of Health Statistics. In 2004, the latest data available, BRFSS reported 76.8% of respondents stated they "have one person you think of as your personal doctor or health care provider". This compares favorably to a 2007 study by The Commonwealth Fund showing that 80% of Americans report they have "a regular doctor or source of care". This latter report delved further into access and found that only 85% of the 80% who said they had a medical home (68% of the total) could say "it was not difficult to contact their provider by phone." And, only 65% of the 80% who said they had a medical home (52% of the total) could say that "it was not difficult to get care or advice after hours or on weekends from their medical home." Both of these access issues also relate to the medical home characteristics of *continuous* and *comprehensive* care, as defined above. In addition, when a fourth component of a medical home regarding organization of the practice was evaluated, the percentage reporting all four components dropped to only 27% of total respondents.

The Commonwealth Fund followed up on this definition by assessing the quality of care received by the survey group. They looked at such indicators as percentage receiving rapid access to appointments, reminders of the need for preventive screening, cholesterol screening, receiving care plans for their chronic diseases, diet and exercise counseling, and blood pressure checks. For all of these indicators, those with medical homes fared better. Not unexpectedly, the uninsured, and minorities were less likely to have a medical home and fared worse on these outcome measures. However, in one of the most striking findings of the study, if the minority and uninsured participants did have a medical home, the disparities in quality disappeared. They found 74% got the care they needed if they had a medical home, but only 38% did without a medical home.

A National Center for Health Statistics survey of families of children with special health care needs was completed in 2001. It showed that only slightly over half (57%) of Iowa children with special health care needs have a medical home - compared to 53% nationally. To determine this percentage, the survey asked families if the child had a usual source of care from a doctor or nurse; if there was a problem obtaining needed referrals; if needed care coordination was available; and if the provider spent enough time, listened carefully, showed sensitivity to values and customs, provided needed information, and made the family feel like a partner.

No segment of our society faces greater challenges than the users of our healthcare safety net. Often uninsured, or isolated by geography, financial status, language or culture, those that rely on the safety net often go without services rather than confront the challenges of accessing care. Thus the language of HF 909 asks each initiative and each participating safety net provider "to assist patients in determining an appropriate "*medical home*." This healthcare policy concept should be highlighted in the Commission's findings, and also should be the cornerstone of any funding proposals resulting from the Commission's work.

The Network's Advisory Group encourages the Commission to recognize the significant opportunity for improved access, quality, and cost that could be realized if we strive to provide all Iowans with a medical home.