Assembly Concurrent Resolution No. 152

Adopted in Assembly July 3, 2014

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Chief Clerk of the Assembly

Adopted in Senate August 14, 2014

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Secretary of the Senate

This resolution was received by the Secretary of State this ____ day of _____, 2014, at ____ o'clock ___M.

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Deputy Secretary of State

RESOLUTION CHAPTER _____

Assembly Concurrent Resolution No. 152—Relative to patient centered medical homes.

LEGISLATIVE COUNSEL'S DIGEST

ACR 152, Pan. Patient centered medical homes.

This measure would state that the Legislature supports and encourages the development and expansion of a California health care delivery system that identifies patient centered medical homes and is based upon certain principles of coordination of patient care.

WHEREAS, Patients frequently confront health care providers working in independent silos that impede care coordination and cause patients with multiple health issues to fall through the cracks; and

WHEREAS, Numerous studies identify fragmented care at the national, state, and community levels as one of the main causes of the poor performance of health care systems in the United States; and

WHEREAS, Patients are forced to navigate an exceedingly complex system with little or no guidance, seeing multiple physicians and other health care providers in various settings; and

WHEREAS, The lack of coordination of patient care, and the lack of communication between patients and health care providers regarding the coordination of patient care, increases inefficiency and the chance of medical errors, waste, and the duplication of costly services; and

WHEREAS, An absence of accountability, quality improvement programming, and clinical information systems leads to poorer quality of patient care; and

WHEREAS, The "patient centered medical home" is a health care delivery system model in which health care providers work in partnership with one another, their patients, and their patients' families to coordinate care, navigate the complex and often confusing health care system, and ensure that patients receive the right care at the right time; and

WHEREAS, Medical homes address the ominous trends in health care, including increasing costs, a shortage of primary care professionals, and the sharp increase in the demand for services for those with chronic diseases and mental health disorders; and

WHEREAS, Several other states have leapt ahead in their commitment to the patient centered medical home model and are reaping the rewards, including, but not limited to, quality improvement and costs reduction; and

WHEREAS, Several other states have obtained substantial federal funding for implementation of medical home demonstration projects; and

WHEREAS, Fee-for-service model rewards volume for services provided, and can unnecessarily drive up the costs and capitation, which can result in the underprovision of services; and

WHEREAS, Inclusion of a blended payment model to support patient centered medical homes tempers the negative incentives of capitation and fee-for-service models and allows for flexibility in how to organize and provide medical home services; and

WHEREAS, Thirty-nine states have created a definition for "medical home," "patient centered medical home," or another synonymous term; and

WHEREAS, Having a definition for "patient centered medical home" in California would send an important signal to health care providers and patients that our state supports care that is patient centered, cost efficient, continuous, focused on prevention, and based on sound, evidence-based medicine rather than episodic, illness-oriented siloed care; now, therefore, be it

Resolved by the Assembly of the State of California, the Senate thereof concurring, That the Legislature supports and encourages the further development and expansion of a California health care delivery system that identifies a patient centered medical home model and is based on the following principles of coordination of patient care, including, but not limited to:

(a) A collaborative team approach to providing comprehensive health care that fosters a partnership among the patient, the physician-led practice team, and other health care professionals, and, if appropriate, the patient's family or the patient's representative, upon the consent of the patient.

(b) The ability to provide access to continuous and comprehensive care, or, if appropriate, referrals to health care professionals that provide continuous and comprehensive care.

(c) A provider, working in concert with a multidisciplinary team of individuals, who takes responsibility for the ongoing health care of patients, including appropriately arranging health care by other qualified health care professionals and making appropriate referrals.

(d) Care that is coordinated and integrated between all elements of the complex health care system, including, mental health and substance use disorder care, and the patient's community.

(e) Care that is facilitated by health information technology, such as electronic medical records, electronic patient portals, health information exchanges, and other means to ensure that patients receive the indicated care when and where they need and want this care in a culturally and linguistically appropriate manner.

(f) A payment structure designed to reward the provision of the right care in the right setting that discourages the delivery of too much or too little care and that encourages the appropriate management of complex medical cases, increased access to care, the measurement of patient outcomes, continuous improvement of care quality, and the comprehensive integration and coordination across all stages and settings of a patient's care.

(g) Compensation that recognizes the increased services and overhead associated with the medical home practice model and the potential savings from better management of chronic diseases and conditions, recognizing the value of non-face-to-face communication by telephone and email, the coordination of care with other providers and community agencies, and the use of health information technology to support medical home functions; and be it further

Resolved, That "patient centered medical home" and "medical home" means a health care delivery model in which a patient establishes an ongoing relationship with a personal primary care physician or other personal licensed health care provider working in a physician-led practice team to provide comprehensive, accessible and continuous evidence-based primary and preventative care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost-effective manner; and be it further

Resolved, That all of the following quality and safety components are incorporated into the patient centered medical home model:

(a) Advocacy for patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between providers, the patient, and the patient's family or representative.

(b) Evidence-based medicine and clinical decision support tools that guide decisionmaking.

(c) The licensed health care providers in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

(d) Active patient participation in decisionmaking and feedback is sought to ensure that the patient's expectations are being met.

(e) Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

(f) Patients and families, or representatives, participate in quality improvement activities.

(g) Patients are provided with enhanced access to health care; and be it further

Resolved, That the Chief Clerk of the Assembly transmit copies of this resolution to the author for appropriate distribution.

Attest:

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Secretary of State