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Medical Home: Is it the future of healthcare?
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The Innovator's Prescription: A Disruptive Solution for Health Care, by Clayton M. Christensen, proposes a solution to the "problems" which our current healthcare system has. The following are some of the comments in the book's introduction:

- "In 1970…healthcare 7% of gross domestic product…In 2007…15%."
- "Health-care spending in the US regularly outpaces…overall economy…last 35 years…all goods and serves has risen…annual rate 7.2%...health care…rate of 9.8%"
- "…if federal...spending remains a relatively constant percentage of GDP…Medicare…will crowd out all other spending except defense within 20 years."
- "…costs of health care…forcing some of America's most economically important companies to becoming uncompetitive in world markets…"
- …if governments were forced to report…the liabilities they face resulting from…health care for retired employees, nearly every city and town in the US would be bankrupt…"
- "Health care is a terminal illness for America's governments and businesses…"
- "…many Americans have begun to look to a single-payer, government-controlled health systems…some governments with nationalized systems…(are) introduc(ing) competing private insurance plans…" (emphasis added)
- "…when caregivers make more money by providing more care, supply creates its own demand…"
- "…we need a system that is competitive, responsive, and consumer-driven, with clear metrics of value per dollar being spent."
- "…political dialogue on health-care reform centers on how to pay for the cost…This book offers the other half of the equation: how to innovate to reduce costs and improve the quality and accessibility of care."

Some of this prescription for our healthcare delivery system can be ignored. Perhaps the key concept in this book is that rather than focusing on how to design a system which we can afford, we need a healthcare system where the care is affordable. This subtle difference is profound. The concept of "afford" often focuses upon quantity, while the concept of "affordable" includes both the concepts of quality and expense.

However healthcare is structured there are quality elements which must be present in order to provide safety, standards, continuity and accessibility. In 1967, the American Academy of Pediatrics introduced the concept of "Medical Home." In 2007, the American Academy of Family Practice, the American College of Physicians (Internal medicine) and the American Osteopathic Association issued a joint statement in which

“Medical Home” was proposed as a solution to the dilemmas which we face as to access to quality healthcare while maintaining the continuity of health care.

In their joint statement, these organizations said, “The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.”

The following principles describe what a Patient-centered Medical Home would look like:

- Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- Whole person orientation – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home. The evidence for quality will be determined by:

- Practices advocate for their 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 physicians, patients, and the patient’s family.
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients’ expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication

- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.
- Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:
- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Fundamental Shift – *Metanoia*

Change has been a part of the human experience since the beginning of time, but it was not until the 18th Century that the concept of progress – change in which the outcomes improve things – became a part of the collective ideals of society in general. The change, indeed, the progress, which needs to take place in healthcare will require that healthcare-provider organizations become "learning organizations." In the terms of Peter Senge's *The Fifth Discipline* a learning organization will have a "shift of mind":

> "The most accurate word in Western culture to describe what happens in a learning organization is one that hasn't had much currency for the past several hundred years…The word is *metanoia* and it means a 'shift of mind'…For the Greeks, it meant a fundamental shift or change…In the early… Christian tradition, it took on a special meaning of awakening

> shared intuition and direct knowing of the highest, of God. *Metanoia* was probably the key term of such early Christians as John the Baptist. In the Catholic corpus the word *metanoia* was eventually translated as 'repent.'
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> "To grasp the meaning of *metanoia* is to grasp the deeper meaning of 'learning,' for learning also involves a fundamental shift or movement of mind…Learning has come to be synonymous with 'taking in information.'…Yet, taking in information is only distantly related to real learning.
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> "This then is the basic meaning of a learning organization…continually expanding its capacity to create its future. For such an organization, it is not enough merely to survive. 'Survival learning' or what is more often termed 'adaptive learning' is important – indeed it is necessary. But for a learning organization, 'adaptive learning' must be joined by 'generative learning,' learning that enhances our capacity to create."

The Medical Home approach to healthcare will require a fundamental shift in the nature of provider organizations in which their learning will become "generative" – creating their future – and not just "adaptive – where they take in more information about how things are around them at present. And, patient-centered care requires a fundamental shift in thinking of providers and in the relationship between patients and their primary care physicians. There must be:

- a higher degree of personalized care coordination
- access beyond the acute care episode
- identification of key medical and community resources to meet the patients' needs

The adoption of information technology for care management and quality improvement along with adequate payment methods are essential. In the long run, the Medical Home is likely to result in savings to patients, employers, and health plans. Increasing the emphasis on primary care could produce large dividends throughout the health care system.

Two trends are helping to build momentum around the medical home model:

1) a growing shortage of primary care clinicians due to adverse practice conditions; and
2) the increasing prevalence of chronic diseases among the U.S. population.

It is important to note, however, that the medical home model is not without controversy. The disease management industry has successfully carved a niche between primary care practices and chronic care patients by calling attention to physicians' lack of attention to patient coaching. Also, studies by RAND researchers and Dartmouth University have quantified the degrees of inaccuracy and misdiagnosis associated with chronic care patients treated in primary care settings. However, Vanderbilt studies and others confirm

that patients prefer coaching by their primary care physician, even while acknowledging that most provide little follow-up support for self-management. Some of the controversies about Medical Home are discussed in a December, 2008 article entitled, *The Patient-centered Medical Home Movement -- Promise and Peril for Family Medicine*.

Why Is the discuss of medical home important?

Primary care is essential for the effective and efficient functioning of America's health care delivery system. It is well established that having a regular source of care and continuous care with the same physician over time has been associated with better health outcomes and lower total costs. We know that states with more primary care physicians show more efficient and effective use of care, leading to lower overall health care spending. Data suggest that increased use of primary care physicians resulted in reduced hospitalizations and reduced spending for other non–primary-care specialist services with improvements in morbidity and mortality rates.

Most everyone agrees that the goal of health reform is personalized, coordinated, comprehensive care that is safe, affordable, and of high quality. Our current payment system encourages high volume, procedures, tests, and referrals. It does not reward the prevention of hospitalization, effective control of chronic conditions, or care coordination. T

Most methods of collaboration central to the medical home, though, are not paid for under much of the current fee-for-service system, such as e-visit consultations and chronic disease management. This lack of relative value placed on efficient, patient-centered care discourages many physicians and mid-level practitioners from providing such services.

Under the Medical Home model practices would:

- Ensure the ability to handle same-day appointments and walk-ins.
- Have Electronic prescribing connected to local pharmacies.
- Have interactive web sites moving patient self management to exciting new levels

  where patients could:

  1) access resources for preventative advice and chronic illness management, retrieve test results Access medical records,
  2) Process medication refills
  3) Schedule office visits
  4) Complete surveys
  5) non-urgent questions could be sent to their personal physician through online communication.

In the medical home primary, care is no longer a single physician craft but a complex set of tasks best managed by a multidisciplinary team. Since chronic illness management and lifestyle modification are central themes in the Medical Home, patients with similar problems could now be seen in groups led by physicians or other team members. The unique dynamics in group visits such as peer support could help with tackling tough problems such as obesity and diabetes.

Finally, critical in the Medical Home is the adoption of electronic health records (EHR). Without HER, medical home cannot and will not work. The tracking of performance measures for quality reporting through chart reviews is inaccurate and costly. Through the technology afforded in EHR's prospective data collection becomes a reality providing the physician with real-time quality measures for the purpose of benchmarking and improvement.

In keeping pace with the future of healthcare, SETMA is taking steps to form a Medical Home for all of our patients, starting with our Texan Plus patients. As part of that process, SETMA is also:

- Applying for NCQA certification of our diabetes treatment program
- Participating in the e-prescribing initiative
- Completing our affiliation with Joslin's Diabetes Center at Harvard
- Participating in the CMS project for reporting quality indicators for our care of Medicare and Medicaid patients.

These are daunting initiatives individually but collectively, they are challenging for they are complex and require us to rethink all that we do; but, for our patients and for our practice, they are the future.