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Medical Home Part VIII:
Why is Medical Home Called Patient-Centered Medical Home?
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Amazing technological innovations have advanced the potential benefit of modern healthcare to a heretofore unimagined level. However, those same innovations unintentionally promoted a reimbursement methodology and an organizational structure of the delivery of healthcare which have to some degree abrogated the promise of those same technological advances.

As the science of medicine grew, due to capabilities and reimbursement, the focus of care delivery came to be on procedures, services and encounters rather than on the global health of the individual patient. And, technology was applied without regard to whether or not it was benefiting the patient long-term and/or creating health. The end-of-life, rather than being a time of reflection, reconciliation and resolution, often became a marathon of hospitalizations, surgeries and extraordinary interventions which neither improved the quality nor add to the quantity of life. Markets were created for "practice enhancement" and new "revenue streams," which focused upon the benefit of the provider without any realization that what often happened was that the health of the patient suffered.

In this system, the patient encounter was directed toward meeting the immediate expectations and interests of the patient without attention being given to the overall "need" and "health" of the patient. "Good medicine." in this system, was defined by a growing patient base, an increasing reputation of the provider as thorough and knowledgeable clinician and the financial success of the practice.

There is no doubt that the patient's welfare was important and that there was no intention of developing a system which was dysfunctional, but it happened. The patient was the focus but only as a snapshot in healthcare delivery, which delivery attended to the immediate, expressed needs of the patient and often not to the implications of evidence-based medicine for the patient's long-term benefit. The snapshot narrowed the focus of the healthcare system to "parts of the patient," rather than providing a detailed portrait of the patent which included hopes, dreams, and humanity, as well as physiology and anatomy.

Finally, the dysfunction in the healthcare system, which was created by innovations and advances, was recognized. Gradually, efforts were made to modify this system and to eliminate the dysfunction. Quality measures were published which allowed the care of one provider to be measured against the care given by another. Preventive care was emphasized, but remained difficult because preventive care was rarely if ever a primary reason for a patient seeing a provider and it was often not paid for by insurance companies including CMS. Efforts were undertaken to move the patient back to the

center of the healthcare equation. Providers began to be encouraged to emphasize points of care other than acute illness.

The compartmentalizing of care by many providers, most of whom were specialists, created a system of incoordination, where patients felt that the only "safe" way to get excellent care was through seeing many different caregivers, each of whom knew everything about one thing but rarely everything about the one patient. Because the payment for this system was based on procedures and studies, costs escalated. Patients associated "good care" with a delicatessen kind of medicine in which they got one of these, one of those and one of another. The care received in this system increasingly lost the focus on the patient as a whole and the health outcome of this system of care deteriorated.

As the demand for quality care increased and as the need for methods of measuring that quality in quantifiable and comparable ways grew, agencies and organizations stepped into the void. One solution to the healthcare-delivery conundrum was the introduction of Medical Home.

Seeing the Patient as a Whole and as the Whole Interest

The concept of a Medical Home is new to most healthcare providers as well as patients. An old idea, which has recently gained momentum, the ideal of Medical Home was adopted by the American Academy of Family Practice, which in 2002 published a monograph entitled *The Future of Family Medicine:: A Collaborative Project of the Family Medicine Community Future of Family Medicine Project Leadership Committee*. That paper concluded with 10 points which addressed the future of healthcare in America in general and family practice specifically. These will be addressed below.

The heart of Medical Home is the patient which is why NCQA's version is entitled Patient-Centered Medical Home. No longer will procedures, tests and things we do to patients be the focus of healthcare – although these will continue to be an important part of the delivery of health – now the patient will be front and center. And, the patient will be the center in all aspects of the healthcare experience:

- The patient will be "in charge," which empowers the patient to be responsible for their care and for their health. In this system, the patient can no longer "turn his/her care over to a provider" and passively expect "health" to happen. The patient has to determine that he/she wants to be healthy and has to determine to take the steps to make that happen. Both the patient and the provider become accountable in this system. The provider cannot do what the patient refuses to, but the patient can now require that the provider provide evidenced-based, quality-measured health care.
- The patient will no longer see the provider as a "constable" charged with imposing care upon the patient, but the patient will view the provider as a colleague, a counselor and a collaborator in the process of the patient retaining, regaining or maintaining health. And, in the end, rather than being a "miracle

worker" who can forestall the inevitable, in this system, the caregiver will compassionately and with care, with family, friends and others, the provider will help the patient through the final days of life. Sometimes this will be done in a healthcare facility but increasingly it will be done in the home.

- The patient's understanding of and education about his/her health condition and/or illness will be the goal of healthcare delivery, particularly in the primary setting. The marching orders for patient and provider will be to realize the truth of Dr. Elliott Joslin's (Founder of the Joslin Diabetes Center at Harvard University) statement, "The patient who has diabetes who knows the most about diabetes will live the longest." Length of life will be more associated with the knowledge and decisions of the patient than with the power and prescriptions of the provider.
- The patient will be encouraged, supporting and followed by the provider not only when the patient is in the provider's office but particularly when the patient is not. Perhaps nothing will be a more fundamental change in the delivery of health care than this point.

As providers modify their work flow, systems, organizations and structures to meet the new demands of Medical Home, they will discover that the complex workflow processes of Medical Home relate to patient convenience, compliance and/or capacity to receive care. These changes are identified by NCQA in many of the 9 standards, 30 elements and 183 data points which define NCQA's requirements for recognition as a Medical Home. Some of these are:

- Follow-up calls after a visit to see if the patient saw the specialist, had the, or got the medication filled.
- Pre-visit reviews to confirm that all information required for that visit is available
- Coordination of visits between multiple providers and/or other service points on the same day
- Evaluation of barriers to care – language, literacy, sight, hearing, transportation, finances, etc.
- Advanced planning so that the patient's desires are known and followed
- Ability for the patient to participate in their care by their documentation of part of their medical record on-line before their visit.
- Ability of the patient to initiate and participate in self education about their major health problems.
- Ability for the patient to document in their medical record the data related their conditions such as blood sugars, blood pressures, weight gain or loss, etc.
- Ability for the patient to communicate with their provider electronically which is efficient and effective.

Heretofore, the convenience of the practice or of the provider was the major consideration in the structure and organization of medical practices. It is a significant and necessary change to focus on the patient's convenience, compliance and capacity to receive the prescribed care. And, the work of the provider has not concluded simply by telling the patient what needs to be done. There must be an evaluation by the provider

and/or his/her staff as to whether that care can be obtained. As a great movie is not a finished product until the film editor has taken the work of the director and producer and spiced it together in an intelligible and deliverable final product, so the Medical Home team just take the work of the provider and make sure that it is package in an intelligible and deliverable final product Without these structural and functional changes, Medical Home can be just another administrative concept, which is a distinction without a functional difference.

Intentional and Incidental

The most innovative aspect of Medical Home and the thing which perhaps distinguishes it from any other well-organized and highly-functioning medical organization is the concept of Coordination of Care. This is the intentional structuring, reviewing, facilitating and practicing of a standard of care which meets all current measures endorsed by:

- National Committee for Quality Assurance (NCQA)
- Centers for Medicare and Medicaid Services (CMS)
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Physician Consortium for Performance Improvement (PCPPI)
- National Quality Forum (NQF)
- Physician Quality Reporting Initiative (PQRI)

The concept of "intentionality" is critical in this process. This is contrasted with "incidental." In health care, most HEDIS compliance and coordination of care are done incidentally to a patient encounter as opposed to the having of a purposeful, provable and persistent fulfillment of national standards of care. Rather than hoping the result is good, Coordination of Care plans and reviews care to make certain that it meets the highest standards. In addition, the content and the process of this Coordination pf Care is report to the patient so he/she can be confident that what should be done has been and,. Or so that the patient can request that what should have been done and hasn't been is done.

The Medical Home intentionally fulfills the highest and best healthcare needs of all patients. In addition, the patient is involved in this coordination by making them aware of the standards and giving them a periodic review, in writing, of how their care is or is not meeting those standards. Patients are encouraged to know and to initiate the obtaining of preventive care on their own. Perhaps the ultimate judge of the success of Medical Home is when healthcare providers hear the following from their patients, "I am here today for preventive healthcare." Today, almost all healthcare providers would tell you that they have never had a patient present with that "chief complaint," or reason for scheduling an appointment.

While Medical Home will ultimately qualify a practice for increased reimbursement from CMS and other healthcare payers, SETMA believes that this method of healthcare delivery is sufficiently promising to develop it with or without change in reimbursement

and not only to apply it to Medicare, Medicaid or Medicare Advantage patients, but to all of SETMA's patients.

It is obvious to us that SETMA's Medical Home will evolve over time. While we will be guided by CMS and NCQA requirements and by the experience of others, it is our expectation that ultimately, we will innovate, experiment and create a unique expression of Medical Home which will fulfill all of the requirements imposed by these agencies but which will also go beyond that as our vision, understanding and experiences increase.

Medical Home Example

As SETMA began to think about Medical Home, we had the following example set before us in February, 2009. In a memo to the SETMA staff, SETMA's CEO said:.

> "My business philosophy is, 'I want it done right and I want it done right now!' Thus, if we are going to do Medical Home, I want it to be done right. As I have thought more about this project, it occurs to me that the dynamic and the potential of Medical Home are found in its name. A 'home' is:
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> - A place where you need fear no harm from those who are in the home with you.
> - A place where your needs are met.
> - A place you can go when you don't know what else to do.
> - A place where you can be yourself and you can tell others how you really feel without fear of rejection, judgment, or embarrassment.
> - A place where others really want to see you succeed.
> - A place where if you are away too long, someone is calling to find out if you are OK.
> - A place where you are treating like family.
> - A place where the safety of one in a crisis or danger is not satisfied until all are safe and secure.
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> "Coupled with excellence of care, Medical Home has the potential for leveraging great benefit for patients and providers from the healthcare delivery equation. Seeing the Medical Home as a reflection of the value and attitudes of "a home," make me think again that what I said this morning is right. I repeat it:
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> "In 2008, the partners of SETMA finalized a 501-C3 not-for-profit foundation – The SETMA Foundation – which has as its purpose medical education and underwriting the care for our patients who cannot afford it. In February, 2009, I saw a patient who has a very complex and fascinating healthcare situation. I saw him during his hospitalization and then for the first time in my office. What I discovered was that he is only taking four of his nine medications because he cannot afford them. I believe in this case, SETMA practiced Medical Home as he left this encounter with:
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> 1. Appointments to SETMA's American Diabetes Association (ADA) approved diabetes self-management education (DSME) program. The fees for the education have been waived. However, while talking to the patient and his wife, I discovered that he could not afford the gas to come to the meetings. He also left with a gas card with which to pay for the fuel to get the education which is critical to his care.
> 2. My staff negotiated a reduced cost for his medications with his pharmacy and made it possible for the pharmacy to bill The SETMA Foundation.
> 3. Because at 60 years-of-age and with his problems he cannot work at his job as a long-distance truck driver, his care also involved counseling him that even in the

face of all of the abuse of the disability provision of Social Security, he can no longer work and I will coordinate his application for disability.

"Gas cards, disability, paying for medications – a part of a physician's responsibilities? Absolutely not! Gas cards, disability, paying for medications, part of Medical Home? Absolutely!

"This patient, who was depressed and glum in the hospital such that no one wanted to go into his room, left the office with a smile and feeling that there is hope. He left as if he had just had a visit to home. It may be that the biggest result of Medical Home is hope. This IS Patient-Centered Medical Home!!"

There is a remarkable story told by a missionary to Indonesia. It is called the *Pineapple Story* and tells the experience of a missionary who fashioned his life for his convenience and for his comfort, only to discover that he was not able to fulfill his calling. It is so with Medical Home. While many of its elements will seem strange and unusual, even objectionable and inconvenient, through the process of developing a patient-centered medical home health care providers will rediscover their mission and their calling. In the end, both the patient and the provider will win – and that is good.