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Medical Homes Series Two
Part VIII Patient Centered:
What Does That Mean?
Your Life Your Health
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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. Often the patient became an object of care, i.e., the opportunity to perform a procedure, surgery or test, rather than the health and wellness of the patient being the principal focus. In addition, the patient is often the passive recipient of care rather than an active participate in their own care.

As the science of medicine grew, due to capabilities and the method of 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 added to the quantity of life. Markets were created for "practice enhancement" and new "revenue streams," which focused upon the benefit to the provider without any realization that what often happened was that the health of the patient suffered, or at the very least did not benefit.

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 a thorough and knowledgeable clinician and the financial success of the practice. And, often the patient was passive and was not actively involved in care planning and execution.

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 given by 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 in-coordination, 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.

In February, 2009, SETMA began the process of developing a Medical Home within SETMA and in reality to transform the entire practice into a Medical Home. In April, 2010, we submitted our application to the National Committee for Quality Assurance (NCQA) for recognition as a Patient-Centered Medical Home and in June, 2010, applied to Accreditation Association for Ambulatory Heath Care (AAAHC) for accreditation for Medical Home and for Ambulatory Care. In July, 2010, we received NCQA recognition as a Tier III Medical Home, their highest, and in August, 2010, SETMA received a one-year accreditation by AAAHC and in August 2011, we received a three-year AACH accreditation for Medical Home and Ambulatory Care.

In 2012, SETMA will submit applications to The Joint Commission and to URAC, two other agencies which endorse Medical Home applications. At the end of that process, SETMA will possess all four Medical Home recognitions and accreditations, which will allow us to comment intelligently about the entire process and about how it can be improved.

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 care – now the patient and the patient's health will be front and center. And, the patient will be the central 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, supported 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. Some of the standards which define patient-centeredness in medical home are:

- Follow-up calls after a visit to see if the patient saw the specialist, had the test, 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 end-of-life 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 to 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 takes the work of the provider and makes sure that it is packaged 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.

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 that SETMA's Medical Home will continue to evolve over time. While we will be guided by accreditation and recognition guidelines and requirements (SETMA has NCQA Recognition as a Medical Home and AAACH accreditation as a Medical Home), we will also be guided by the experience of others. We will continue to 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.

SETMA's Medical Home will be different from others but it will be the same in that it will fulfill the mandate for patient's to be engaged in their own care and for patients' desire and wishes to be given consideration in their health care.