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How Our Healthcare System Evolved and How It Must Change
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 a 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 provided 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 Medicare and Medicaid. As care evolved efforts were undertaken to move the patient back to the center of the healthcare equation. Providers began to be encouraged to emphasize preventive care and health maintenance rather than just dealing with 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 deterioration.

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.

The concept of a Medical Home is new to most healthcare providers as well as patients. But medical home is an old idea, which has recently gained momentum. In 2002, the ideal of Medical Home was formally adopted by the American Academy of Family Practice, with the publication of 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.

The heart of Medical Home is the patient which is why National Committee for Quality Assurance's (NCQA)version is entitled Patient-Centered Medical Home. No longer will procedures, tests and things 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:

In the past five years, SETMA has worked toward transforming into a patient-centered medical home. SETMA ahs been recognized by NCQA as a Medical home since 2010 and has had that recognition renewed for an additional three years at the highest level. The Accreditation Association for Ambulatory Health Care (AAAHC) has accredited SETMA as a medical home for the same period. In the next few months, SETMA will gain accreditation by URAC and by The Joint Commission. With the endorsement of the four agencies offering medical home recognition,

SETMA will continue pursuing the structure and dynamic of patient-centered care which will resulted in the following:

- 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.