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The Place of Patient-Centered Medical Home
in the Future of Healthcare Delivery
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In our ten-part series on patient-centered medical home, recently published in the *Examiner*, we have examined the concepts and content related to the old, now new, concept of Medical Home. The interest in this re-formation of healthcare delivery is accelerating, as is evidenced by the following.

The 795-page, U.S. House of Representatives' marked up heath reform bill has been made public (July 15, 2009). It includes language which begins the process of rewarding healthcare providers who are practicing Medical Home. The following is part of Section 224 entitled, "Modernized payment initiatives and delivery system reform," which addresses innovations which are hoped will bring increased value, improved quality and decreased cost to healthcare delivery in the United States. It states in part:

> "the Secretary may utilize innovative payment mechanisms and policies to determine payments for items and services under the public health insurance option. The payment mechanisms and policies under this section may include **patient-centered medical home and other care management payments, accountable care organizations**, value based purchasing, bundling of services, differential payment rates, performance or utilization based payments, partial capitation, and direct contracting with providers. (emphasis added)

"…The Secretary shall design and implement the payment mechanisms and policies under this section in a manner that seeks to—

A. improve health outcomes;
B. reduce health disparities (including racial, ethnic, and other disparities);
C. provide efficient and affordable care;
D. address geographic variation in the provision of health services; or
E. prevent or manage chronic illness; and

promotes care that is integrated, patient centered, quality, and efficient."

The bill further identifies the metrics on the basis of which permanent funding of Patient-Centered Medical Home will be considered by the Secretary of the Department of Health and Human Services. Addressing this point, the bill states that the secretary will implement a pilot program for the evaluation of cost and quality in order to determine:

"...the extent to which medical homes result in

1. improvement in the quality and coordination of health care services, particularly with regard to the care of complex patients;
2. improvement in reducing health disparities;
3. reductions in preventable hospitalizations;
4. prevention of readmissions;
5. reductions in emergency room visits;
6. improvement in health outcomes, including patient functional status where
7. applicable;
8. improvement in patient satisfaction;
9. improved efficiency of care such as reducing duplicative diagnostic tests and laboratory tests; and
10. reductions in health care expenditures; and

"…the feasibility and advisability of reimbursing medical homes for medical home services under this title on a permanent basis."

SETMA's involvement in Patient-Centered Medical Home began at a lecture in February, 2009. Since that time, we have expended a great deal of time and energy in working toward the development of Medical Home functions within SETMA. The week of July 20th, representatives from SETMA will be attending a meeting in Washington, DC presented by the National Committee for Quality Assurance (NCQA) on Patient-Centered Medical Home. This conference is the last step in SETMA's preparation for applying for designation by NCQA as a Patient-Centered Medical Home.

Other interest in Medical Home and SETMA's involvement in this movement are:

1. July 14, 2009, SETMA made a two-hour presentation to the national sales meeting of a major electronic medical records vendor on Patient-Centered Medical Home. This EMR Company, NextGen, is making strides toward providing the functionalities needed to support the requirements of recognition by NCQA as a patient-centered Medical Home.
2. August 4, 2009, a group of physicians and staff visiting SETMA from Scott and White Clinic will be spending the day to review SETMA's preparation for becoming a patient-centered Medical Home.
3. August 18, 2009, a group of physicians and staff from SETMA will be visiting the Texas A&M University School of Medicine in College Station to discuss their interest in EMR and in Patient-Centered Medical Home.
4. September 18-19, SETMA has been invited to join a conference of family medicine leaders from around the country. Representatives of SETMA will participate in this conference of physician leaders in Dallas to discuss Patient-Centered Medical Home. The official title of the group is "Family Medicine Leaders in Large Multi-specialty Groups." They meet twice a year to discussion advancements in healthcare delivery. Large groups who are members of this group include: Scott and White, Marshfield Clinic, Geisinger, Oschner, Mayo, Group Health, Duluth Clinic, Austin Regional

Clinic, Kelsey Sebold, Park Nicolette, St. Johns Clinic and Sharp Reese Stealy.

5. November, 2009, SETMA will make a presentation to the NextGen User Group meeting in Washington, DC on Patient-Centered Medical Home and Chronic Disease Management.

These and other opportunities indicate the growing momentum for this transformative initiative in healthcare delivery.

In context, Patient-Centered Medical Home may represent another in innovative changes which have transformed how SETMA is delivering healthcare. The first was the formation in 1995 of the foundations of a multi-specialty medical group in Southeast Texas. It had never been successfully done and it has proved to be a benefit to our patients and community.

The second was the adoption of electronic patient records (EMR) in 1997. At the time, it seemed that this effort might be a very expensive and difficult experiment in futility, but it has proved to be a critical and necessary step toward the transforming of healthcare. At www.jameslhollymd.com under the section Your Life Your Health, there is a great deal of information about the process of our transforming SETMA through EMR.

The third was the realization in May, 1999 that an electronic means of documenting a patient encounter was an inadequate goal. What SETMA really wanted to do is to develop electronic patient management (EPM). EPM meant that the EMR would be a tool to provide leverage for improving the quality of care and thus the outcomes of healthcare delivery. It meant that it was imperative that we develop disease management tools which would standardize the care all patients received from SETMA.

It meant that the same data base, and consequently the same decision-making information would be must be utilized at all points of care. SETMA realized that continuity of care involved all providers using the same data base at every encounter with every patient. Thus SETMA developed the ability to use the EMR and thus EPM in the clinic, in the emergency room, in the hospital, in the nursing home, in physical therapy and in any other venue where our patients received care. Electronic patient management provided excellent continuity of care in that all data and the same information was available everywhere.

This was illustrated in 2000, when a patient was admitted to one hospital. The history and physical examination (H&P) was prepared in the EMR. Subsequently, a few hours later, the patient was transferred to another hospital. The patient's condition has rapidly changed, in this instance for the better. Instantly, the H&P from the first hospital was available at the second. A subsequent evaluation was done at the second hospital and four hours later, the patient's condition had changed so dramatically that even thought he had been in the ICUs of two hospitals, he was able to be discharged to home the same day.

The patient's record included:

- An H&P from the first hospital
- An H&P from the second hospital
- A follow-up note from the second hospital
- A discharge summary from the second hospital.

The quality and continuity of care was excellent, principally based on the availability of information and data at every point of care. The cost of the patient's care was efficiently managed without any sacrifice in quality. The patient's satisfaction was high in that he wanted to go home when it was safe. The patient's follow-up care was outstanding in that all of the information was available to his physician at his follow-up visit in the clinic.

The benefit of SETMA's EMR and EPM initiatives was seen in 2008, when SETMA was able to query our EMR to analyze the quality of care our patients with diabetes had received. The data reviewed that there had been steady and progress improvement in the outcomes of our care over the past eight years. The data showed that there were three points at which that care had dramatically improved within a year.

Review of this data showed that the dramatic improvements had come when:

1. SETMA created a diabetes disease management tool in the EMR which enabled us to leverage the power of the EMR for electronic patient management.
2. SETMA developed an American Diabetes Association accredited Diabetes Self-Manement Education program.
3. SETMA recruited an Endocrinologist.

Now we come to Patient-Centered Medical Home. SETMA believes this will be the next major innovation and advancement in healthcare. Done properly Medical Home can e transformative in healthcare delivery at least as much as EMR, EPM and effecvtige continuity of care.

Currently, the only complete description of Medical Home is that of NCQA. In that description, there are 9 Standards, 30 Elements and 183 data points. SETMA has spent a great deal of time determining whether we are fulfilling each of these standards, elements and data points. For us, it is our apprehension that it is possible to meet all 183 data points and not to achieve the promise of Medical Home.

In our judgment, the success of Medical Home will be measured by:

1. how engaged the individual patient is in this/her own care
2. how effectively providers are in helping patients make life-style changes which actually improve health and prevent illness

3. how rational the healthcare choices are which are made by patients and families as healthcare choices will be made rationally by patients and families are surely care will be “rationed” by the health insurer which may become the government.
4. How consistently evidenced-based medical therapies are utilized with all patients.
5. Whether Medical Home does result in improved care, decreased cost and prevention of chronic disease.
6. How successful we are in education of people and in convincing people that if they make a change in their habits and/or choices that that change will make a difference in the quality and quantify of their lives.

A true Medical Home will go far beyond tradition interests and responsibilities of healthcare providers. A true Medical Home will have to begin to address the social, cultural, sometimes ethnic, financial, and even religious barriers to good health and rational healthcare choices and decisions.

Medical Home must engage the recipient as an active agent and as a responsible participant. The question is what do we do about the millions of people who will not cooperate with their own health and/or who either will not, or cannot begin to make healthy choices in their lives? Changes in the administration, financing or access to medical care cannot correct and make up for all of the "bad choices" people have made and/or continue to make in their lives.

In SETMA’s Medical Home initiative, we have begun to discuss, ‘How can we get people to make the right choices?’ The reality is that we can't threaten them. Of course, with smokers, we have been telling them that if they don't stop smoking we will not continue to care for them. As a result many have stopped. Yet, when you begin to deal with nutrition and activity habits, it is probably not possible to make that bargain.

Our frustration -- and it is a frustration -- has arisen from the fact that we KNOW how to help people improve their health. Nonetheless, many patients' health does not improve because they are unwilling or unable consistently to make the choices which are required to become healthy. What do you do with a person who knows, that if they continue to overeat and under exercise that they will die, and yet they don't change? What do you do with a person who knows, if they don't stop drinking alcohol, that they will lose their family and their life, but they don't? What do you do with a person who knows if they don't take their medication, they will become sicker, but they don't?

Healthcare problems for most people are not in their heart, their arteries, their intestines or their joints; the problem is in their heads. There is no simple solution, but a great deal of it has to do with hope and/or the lack of hope. Without hope, human beings begin to die. And, while it is true physically, it is also true mentally, emotionally and spiritually, human beings begin to die from the inside out. If our Medical Home is going to be anything but a form, it must address these non-medical issues.