

MINNESOTA FAMILY PHYSICIAN

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Legislative Session a Success for Family Physicians

By Dave Renner, MAFP Legislative Representative

The 2007 Legislative Session completed its work on May 21, and it was a very successful session for the MAFP. The Legislature adopted the Freedom to Breathe Act that prohibits smoking in most all workplaces, including restaurants and bars. This is a major accomplishment that will protect all workers and patrons from the danger of secondhand smoke. In 1975 Minnesota lead the nation by passing the first clean indoor air act regulating smoking in restaurants and bars. We have now become the 20th state to prohibit smoking in these settings altogether.



In addition the Legislature increased coverage for 37,000 uninsured children and 17,000

uninsured adults. This was done by eliminating many of the cuts in eligibility that the Legislature passed during the many years of budget shortfalls. This will hopefully stop the tide of increasing numbers of uninsured that the state has experienced over the last few years.

The Legislature also approved a new tool designed to assist physicians in reducing the number of patients who are “doctor shopping” looking for narcotics. The Board of Pharmacy

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What is a Medical Home?

By Dave Hutchinson, M.D., MAFP President-Elect

And where is it? Or who is it? What's in it, and who's there when you knock?

The Medical Home is a phrase, a concept, now oft-referenced in conversations about reforms in healthcare delivery and healthcare finance. It is a phrase that offers a context for the re-promotion of primary care in some of those same conversations. It suggests a patient-driven, personal physician-led structure for care delivery. Its components and goals are research-proven to work well for you and your patients, providing superior care outcomes, with superior value, efficiency, and satisfaction.

In 2005, the MAFP Board composed a position paper on the Medical Home, outlining its importance in Minnesota's future healthcare landscape, and highlighting core principles which we feel defines it. This work closely reflects the

2007 'Joint Principles of a Medical Home', agreed upon by the AAFP, the AAP, the ACP, and the AOA.

'The Joint Principles of the Medical Home' added a core tenet in support of compensation reform, to allow robust accomplishment all of the above.

State and national leaders have endorsed the Medical Home as an important focus of transformation. The MAFP now feels that vigorous promotion of the Medical Home concept is one of our most important initiatives, as a service to members, and a service to Minnesota. Our efforts to educate members and the public are on our website, and have occurred in advertising, local talks, and officer addresses. We're developing a full plan for marketing the

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Medical Home to public, member, legislative, and payer audiences. This article, now, will launch a discussion series designed to further acquaint members with Medical Home language, and to consider practical issues and offer suggestions about how to construct medical homes for our own patients.

Through what structure, what mechanism, should these principles be served? Is a family doctor actually the medical home? Or is it a building? My clinic? Must personal physicians be primary care doctors? How can every clinic or physician offer comprehensive care? What specific services or resources are there?

Home is where you're safe, valued, tended. A Medical Home is a concept which describes a system, or a set of health resources. It is a point of care entry to a system which is structured to accomplish the goals of its defining core principles. It is an entity which is committed to (and which should be reimbursed for) offering the quality and type of health care that all patients deserve; that is, it offers care which is:

- Free of barriers to access

- Relational, supported by trusted connections with *personal physicians*, experts in medicine, who come to know, care for, and feel responsible for patients over time, who ensure recording and conveyance of the patient's health story for accurate use by other caregivers, and who serve as a team point person for care oversight.

- Coordinated centrally through physician direction, use of updated health records, and through reliable communication between team members and all network consultants.

- Patient-Centered, delivered according to patient needs and priorities, culturally sensitive, employing patient feedback and patient direction in policy formulation.

- Comprehensive, using team member expertise, and maintaining collaborative and cooperative relationships with a full range of care settings and specialties.

- Committed to quality, safety, and improvement, through use of evidence, technology, collaboration, system design, and self-inspection.

Those guidepost principles emphasize the use of care teams, care plans, active partner and team communication, information records and transfer, knowledge bases and decision-support tools and Q.I processes, provision of basic and preventive services along with access to all other care services, and a culture of patient-centricity which should guide how we structure our care policies and facilities. They imply the sharing of responsibilities, with an eye toward provider and clinic health. They also continue to emphasize continuity relationships as valuable at all points of care.

A Medical Home can be represented by a multi-specialty organization, a primary care clinic, a consortium of facilities, a solo practitioner, an e-connection between a patient and physician. Any of these structures, and more, could honestly call itself a Medical Home, IF it is openly available, IF it is networked and communicates actively with a complement of resources which can offer full cares to patients, IF its policies and habits actively employ the value of relationships between patients and doctors who know them, and IF it administratively and culturally places the patient at the center of considerations.

We believe strongly that for healthcare to be healthy – accurate, cost-effective, safe, meaningful, and kind – every person should have a Medical Home.

Each of those above types of systems is faced with its own challenges in accomplishing the goals of a Medical Home. Each can do so, with focus and commitment. We recognize that the details of Medical Home design will vary between our settings and systems, but that in general, achievement of its aims is as possible and practical as it is desirable. We recognize challenges: How can docs located distantly from a hospital provide continuity-physician care in both clinic and hospital settings efficiently? How can clinics ensure timely admission and discharge communication with hospitalists or emergency physicians employed by separate parent hospital organizations? How can outside care occurring for the patient effectively become a part of their health record? Do we have the time, and the money, to honestly coordinate care across the system so adeptly? How can we make the EMR an instrument of wise practice, rather than a primary task itself? Pshaw. Watch our dust.

The Medical Home represents values which speak to all of us. Its principles could also seem ephemeral, or impractical given certain financial, workload, and partner-support exigencies. It is important that we believe we can build them fully, though. It is through Medical Homes that we will successfully achieve the safety and accuracy goals outlined by the Institute of Medicine *while at the same time* personalizing and coordinating medical care for patients in the ways we know are healthy and gratifying according to traditionally continuity, whole person, and comprehensive care values of Family Medicine, *while also at the same time* accommodating the modern lifestyle goals of community physicians, in the context of our current practice resources. It is through delivery of care demonstrably according to Medical Home principles that we will achieve substantive compensation reform. Maintenance of healthy Medical Homes is also our ticket to renewed professional satisfaction – they will accent our effectiveness, value, connections to patients, and will reorient the general design of healthcare. Student and partner recruitment will follow all of these things. Construction of Medical Homes isn't just a social imperative; it is in our best interests.

Our next issue will focus on Coordination of Care in the Medical Home. Please share your observations and reactions to any column or topic in this series, on our website message board for members at www.mafp.org.