

Three years ago upon his installation as president, George Schoephoerster, M.D., told you he wanted to be a cheerleader for Minnesota family docs; he told you that you could, you must “do it”. He exhorted you to be excellent, to stay connected to patients as their personal physicians, and to focus on delivering care within the context of a Medical Home.

Two years ago, Randy Rice, M.D., spoke about shining a spotlight on ourselves as people in our profession – focusing on making healthy examples of ourselves to our patients.

Last year, Lynne Lillie, M.D., offered a wistful look back (to the future) at our roots. She reminded us of the advanced level of value in patient care offered by the old GPs. She suggested that with modern mechanisms and knowledge, a return to Marcus Welby medicine could be a good thing. That’s a vision that faces challenges in today’s professional climate and culture; we’re skittering away from the comprehensive skill application and ubiquitous availability implied by the image. It’s an insightful vision, though. She went on to highlight some of the structural elements of a Medical Home that would be necessary to support such a person in a modern and healthier context.

While pondering how to inspire you next, it struck me how those three presidential address themes combine to highlight the extent of our needs and patients’ (society’s) needs. We really do need it all. Americans need a safer, better-coordinated, more trustable, personable, and informed, and cheaper, health care system. Family Medicine is poised to help deliver that. We’re at a point, though, where – to survive as a specialty – we need healthy and fun personal and family lives, and we need some distance from practice sometimes. We also need the meaningful connections we develop with patients, and we need professional privileges and skills extensive enough to gratify us and make us effective, attaching us to practice, still. We need multiple layers of support resources, we need more partners, we need public advocacy for systems which compensate us constructively, we need the house of medicine to find more value in us. We need the energy and vision to promote all of the aforesaid, and we need the resilience to change, so that we can navigate the way there. We need a lot. It’s hard to envision all of that.

“The future belongs to those who believe in the beauty of their dreams.” - Eleanor Roosevelt

I really do believe in the beauty of what I dream to be a healthy health care system. THAT IS a system:

- which emphasizes and is coordinated by **primary care**
- which is built around **longitudinal relationships** of caring, trust, and accountability between patients and clinicians
- which is buttressed and lubricated by **technology and evidence**
- where patients are empowered and engaged in health management and systems management
- where clinical assessments and treatment decisions are driven not by economic force on clinical production, but by patient needs, physician concerns, and the knowledge that collates medicine with ‘patient’

President's

Message



By David Hutchinson, M.D.

- where cost effectiveness and value are rewarded
- where primary care clinicians are attached contentedly to a comprehensive service mission, available, confident in their many skills, and revered in the medical community for their:
 - expert generalism
 - discerning eye
 - ability to manage complexity
 - insight into individual patients
 - versatility
- where personal physicians are supported by interactive relationships with skilled sub-specialists whose expertises are accessed liberally
- where we employ help from multiple other clinic care team members
- where all elements of the system are happily connected and work smoothly together
- where we’re well-known by our families, well-rested, well-exercised, well-enough paid, well-supported by the right number of equally skilled and equally well-tended partners

Am I just “dreaming”? Is this where I should toss in the palm trees and cool ocean breezes? All realities begin with a dream, of course. I know this poignantly; my dad is building a house right now in the Bahamas.

The MAFP Position Paper on the Medical Home Outlined Six Core Principles:

Enhanced Access	The Personal Physician
Comprehensive Care	Quality & Safety
Coordination of Care	Patient Centeredness

This is what I envision. We need all of this! Some of you have succeeded at creating work situations that approach that utopian vision. Some of us are still striving to build Shangri-La, though, and some of us have felt compelled to simply aim ourselves at different goals, with preservation of the ‘self’ being prominent among them. But that whole package – that’s still my dream, and it still looks beautiful to me.

“The best way to have a good idea is to have a whole lot of ideas, and throw out the bad ones.”
- Linus Pauling

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It has been unexpectedly easy to market the comprehensively conceived Advanced Medical Home. That's because it's one of those really great ideas. *Patients and society want all of those same things that we need.* They feel vulnerable. They're scared about runaway costs and runaway medicine, they know they're not in control, they know the left hand often doesn't know what the right is doing. They want what we need. They want healthy, smart, happy doctors, they want us to keep their needs at the center of considerations, they want us to know who they are and where they've been, they want input, they want affordability and value, they want elements of the system to work in concert with each other. And they deserve those things as much as we do.

Several things about the Medical Home model of care should really rev our engines. First, it *re-centers healthcare around primary care* for better care coordination. We instinctively know – and evidence stoutly supports us in this knowledge – how comprehensiveness, generalism, and continuity produce superior outcomes, patient satisfaction, and cost efficiency – ‘the golden triad of result’. To excel as an overall system, healthcare has to emphasize primary care, and to excel as complex system, healthcare has to be coordinated by a primary care hub, which itself can reach a lot of spokes out to a lot of other experts. We used to think we worked in a system like this, but in many settings we're no longer at the conductor's podium. I'll be excited to see care delivered more symphonically.

Second, it aims to be completely *patient-centered*. In a production-driven professional culture, haste and ‘efficiency’ drive us to hurry visits, make quick decisions, order tests quickly, defer elements of service to other providers and locations, and overlook patient needs. How reliably can our patients access language interpreters, social workers, and care coordinators? How much time do we actually devote to verified patient education? With what quality and reliability does information flow between care providers and care settings? How thoroughly do our QI processes work? We work really hard at it, but a treadmill doesn't move us forward, no matter its speed. We need different incentives, new vision, and reclarified intentions. The Medical Home gives us those things.

Third, it does a fantastic job of outlining pathways to better *coordination of complete care*. The Minnesota DHS has composed a plan to pay recognized Medical Homes for coordinating care excellently for high-needs patients. They foresee our use of seven general, evidence-based mechanisms to do this. They are: 1) patient registries and disease registries; 2) care plans; 3) care coordinators; 4) patient and family engagement; 5) community resource and consultant engagement; 6) practice based QI, evidence-based measures, and data analysis; and 7) participation in a Medical Home learning collaborative.

Fourth, the Medical Home re-champions the *Personal Physician* as a touchstone point of continuity, as the purveyor of the patient's story, as a coordinating leader of a team of clinical caregivers. I love this. It heralds help for the weary and leery, but also re-promotes the critical nature of the two entwined roles of the Personal Physician – generalism and continuity. All patients deserve assurances of both of these.

One goal for me this year is to stand as a champion of the NEW Personal Physician. You've always been my heroes for your dedication as generalists and continuity physicians. You're even more so now, for I'm realizing how you've generously helped the whole rickety health care system gimp along. Patients are still served because you are there for them.

The very same goes for the new model of care. Without the Personal Physician, the Medical Home can crumble. By its nature, conscientiously observed continuity-based care ensures *patient-centeredness*, contributes to *quality and safety*, guarantees patients a sense of *access*, and facilitates insightful *care coordination*. The Personal Physician is the cohesive entity which binds the goals and tenets of the Medical Home together.

I believe that it is in patients' and our best interest to be sure that we remain a prominent and measurable part of the definition of the Medical Home, especially if we want to re-tilt the system, and tap effectively into the compensation reform movement that will be tied to practice recognition as Medical Home hosts. This will be a big part of my work for you – making sure that policy-makers know how critical you are.

What really caught my eye about the Medical Home was how it revealed itself as a potential bridge between generations of care providers, or between paradigms of care. It can help us be excellent in both old and new ways. On one hand, the concept and its structure really do embrace traditional values. You can readily identify those in the six core principles of the Medical Home. But it promotes the accomplishment of those values by highlighting them as important clinical practice *goals*, emphasizing *data management* and *communication* tools, providing us with new *team partners* and infrastructure, and advocating for *enhanced compensation* for care coordination.

If you think about it creatively, those are tools that can allow us to accommodate more focused (subdivided) practices and more appealing levels of clinician availability, without failing any of the goals of care, including the safeguarding of continuity. This seems really big. We have to share, partner, and communicate effusively about patients. (Imagine how effectively hospitalist systems and part-time positions could work if we heed those tasks assiduously.) It is a rededicated focus on the goals of continuity and coordination in the Medical Home, with the use of new and accentuated mechanisms and the assurance of compensation for the time they entail, which gets us there.

Another goal for me, is for you to feel that I represent all of you. That's no small order. Even united in the common theme of wanting to do well by patients, we live varied lives and practices, by diverse sets of priorities, with different vision. Being a champion for pervasive evolution in Healthcare structure, toward construction of Patient-Centered, Primary Care-Coordinated Medical Homes, will be one way for me to advocate for all of you simultaneously and together.

All realities begin with a dream. When I dream of the Medical Home, I think of its core principles, and I think about “HOME” – what it means to those who reside there, and what it takes to operate one to promote health and functionality. To me, “HOME” is where you're safe, tended, valued, and known. I think we should believe that *as caregivers, we all fit into a home like that.*