The Minnesota Academy of Family Physicians
Position Paper on the Concept of a Medical Home

Adopted, March 11, 2006

Executive Summary: The Medical Home provides an easy-to-use point of entry into the health care system, coordinates ongoing, comprehensive medical care that is appropriate and consistent with the patient's needs and values, and places the patient at the center of all choices concerning their care. The Medical Home's structure supports the patient establishing and maintaining long-term relationships within the medical team, while utilizing health information technology and other innovations to provide seamless and timely access to all essential care.

The Minnesota Medical Association has proposed a model for healthcare reform that has four interconnected features. Those features are an expanded public health system; universal coverage including an essential benefit set; changes in incentives in the delivery of care to create better value including putting the patient at the center of all choices concerning their own healthcare; and increasing the amount of effective care that is being provided. The MMA's reform proposal states that one essential element to providing more effective care is for the Minnesota health care system to focus on, and financially support, continuous care to a patient in the context of a Medical Home.

In 2001, in its publication, Crossing the Quality Chasm, the Institute of Medicine (IOM) described how to best attain more value in any health care proposal. They listed 6 performance characteristics, or aims, that they felt would need to be part of any successful reform proposal. Those aims are:

- Safety—more effectively accomplished when it is approached as a systems issue.
- Effectiveness—this means providing services that are of benefit. That is, the care must be evidence-based and must avoid both overuse and underused of services. Another way to say this is that the services must be essential.
- Patient-centeredness—the health care system must respond to the individual patients needs/values and those then must guide all clinical decisions.
- Timeliness—the structure of the system must avoid wasting the time of all involved.
- Efficiency—reducing overuse, reducing errors, and decreasing production costs.
- Equity—both for the population and for the individual patient.

To achieve these aims, the IOM proposed that an effective health care system must be structured on the following 10 rules.

- Care needs to be based on continuous healing relationships. The IOM's focus here is on the concept of continuous. They recommend moving from encounters (office visits) as the definition of care to a continuous healing relationship in which a patient can have access to trustworthy information and the health care support that they need 24 hours a day, 7 days a week, 52 weeks of the year, in a setting where that patient is known as an individual.
- Care needs to be based on patient's needs, choices, and preferences…that is, it must be patient-centered.
- The patient needs to be the source of control…that is, the patient must be at the center of all choices concerning their own health care.
- There needs to be shared access to a free flow of information. This implies that patients, in addition to care, receive medical information from their provider and that they then receive help in utilizing that information in a manner that is consistent with their own values.
- Care must be evidence-based. The IOM feels that conflicts between this rule and the rule that the patient is the source of control may best be summarized by this statement, "The patient is always right, but sometimes the doctor, as the expert in evidence-based care, knows best!"
- Safety must be addressed as a systems property.

- There needs to be transparency, so that everyone involved can make informed decisions.
- Patient's needs must be anticipated. That is, care should be structured in a proactive mode, rather than a reactive mode. Our current structure is to predominately respond (reactively) to the chief complaint that the patient raises when the provider enters the room. This change would imply, among other things, the need for implementation of (and reimbursement for) a chronic disease model of primary, secondary, and tertiary prevention.
- There should be a continuous decrease in waste, both in time and in resources. It would require significant changes both in the flow within our offices and how our offices interact with the greater health care system.
- Clinicians must work as teams, cooperatively and collaboratively.

The Medical Home provides an easy-to-use point of entry into the health care system, coordinates ongoing, comprehensive medical care that is appropriate and consistent with the patient's needs and values, and places the patient at the center of all choices concerning their care. The Medical Home's structure supports the patient establishing and maintaining long-term relationships within the medical team, while utilizing health information technology and other innovations to provide seamless and timely access to all essential care. The development of these long-term relationships allows the health care team to learn how to best accommodate each individual patient and the patients to develop trust in the team that is caring for them**.** It is this trusting relationship that then allows the patient, in concert with their own personal physician, to make more informed decisions about their own healthcare in a manner consistent with their own values. More effective care is provided earlier and in a less costly manner when seamless and timely access to all essential care is provided for a patient by eliminating all barriers to its access. These barriers are eliminated by the seamless integration of all of one's health care, which includes either its provision at the Medical Home or the facilitation and coordination of that care elsewhere within the health care system. Finally, an appropriately structured Medical Home will strive for optimum quality by including continuous quality improvement as a fundamental tenet. Structured in this manner, a Medical Home would fit the IOM's rules for health care reform and would then provide more value to the health care system.

The Six Fundamental Principles that are an essential part of a Medical Home:

1) Easy accessibility for **first-contact** care for any health problem or need.
2) Continuous Care (**continuity of care**), which is accomplished in the context of a long-term relationship with a care team led by the patient's personal physician, who coordinates an inter-professional dialogue among all the various members of the patient's care team within the entire health care system.
    - Continuous Care allows familiarity with the intricate details of a patient's life over time, which is essential in developing trust in the health care team.
    - Continuous Care necessitates ready access to all of the patient's medical information.
    - For care to be effective, it must be individually relevant. As such, it requires a relationship of both trust and responsibility with the patient's personal physician. This relationship is the essential element that will lead both to personalization of care from the health care team and to informed decision-making by the patient in a manner that is consistent with their own personal values. For the Medical Home model to be successful, it must be structured in such a way as to make the continuous relationship of trust and responsibility practical and meaningful for both the patient and the patient's personal physician.
3) **Comprehensiveness** of care, where any and all health care needs are either provided or coordinated. In doing so, the Medical Home model relies on the support of extensive resources from throughout the health care system.
4) **Coordination** (and facilitation) of all essential care for the patient, regardless of where it is provided.
5) Family and community orientation with cultural competence, which means **caring** for patients **in** the **context** of their social environment.
6) **Continuous quality improvement** processes are incorporated to make it ever more likely that every person will have the right access to essential care at the right time without needless pain or suffering (that is, the care is safe) in a manner that avoids the wasting of time and resources of everyone involved.

The attributes of a Medical Home that follow from these key principles. **The Medical Home:**

- Is structured to be an easy-to-use point of entry into the healthcare system where patients can establish and maintain an ongoing relationship with a health care team, lead by their own personal physician, to receive care that is comprehensive, seamless, patient-centered, culturally sensitive, and safe.
- Provides the necessary structure to allow a patient's personal physician to simultaneously utilize both the science of medicine and their own longitudinal knowledge of the patient in providing effective care.
- Provides the structure needed for appropriate, essential, and humanizing care that is always available, meaning it can be face-to-face, online, over the phone, at home, at the nursing home, in the hospital, or wherever and whenever that care is needed. This structure will include current medical knowledge of the patient at all points of care.
- Provides all of the necessary structure for maintaining ongoing relationships that are satisfying to both patients and providers.
- Is the center of communication that supports and coordinates the patient's care. This includes information to and from all professionals involved in that care, including interaction with any community agencies that will ensure that the patient's health care needs are adequately and appropriately being addressed.
- Has the necessary structure to provide access to all locations and levels of medical care, which are then utilized effectively for the benefit of the patient.
- Provides all of the essential health care documentation for a patient (medical leave, camp physicals, disability, etc.) and maintains a current and integrated electronic health record.
- Utilizes a team approach to care with efficient and effective communication that is supported by the availability of shared information through that electronic health record. This team is led by the patient's personal physician.
- Is efficient, yet it respects the time of patients by allocating the necessary time for effective listening and for comprehensive and thorough evaluation, treatment, and/or referral.
- Provides for the seamless integration of all personal health care (including the coordination and facilitation of all collaborative care), which should include the following examples of health care services: health care to children and adults, maternity care, disease prevention, health assessment and promotion (including lifestyle modification), patient education and support for self-care, primary mental health care, the diagnosis and management of acute injuries and illnesses, the diagnosis and management of chronic diseases, hospital care, supportive care including that at the end-of-life, patient advocacy within the health care system, and practice-based research.
- Is structured to be self-improving through continuous quality improvement processes that include patient input.
- Is structured to provide population-focused care by the health care team.
- Utilizes the information that is gathered about its own patient population to evaluate how to provide better services, integrate new methods, implement new treatments, discover new diseases, and improve the science and understanding of medicine through research relevant to the delivery of primary care.
- Examples of innovation that are currently being tested in practices across the country in an attempt to improve the ability of a Medical Home to provide patient-centered care include: open access scheduling, group visits, electronic health records, patient-involved practice councils, chronic disease care, patient disease registries, e-health care, and population-based care.

Evidence for the Effectiveness of the Medical Home Structure

There is a growing body of evidence in the literature showing that the Medical Home model does create more value for the health care dollar by establishing those practice systems essential to the provision of patient-centered care. The concept of a Medical Home was started by the specialty of General Pediatrics as a way to describe the structure required to provide for the complex health care requirements of its special needs populations, meaning those pediatric patients with chronic disease. Then in the late 1990's, the specialty of Family Medicine undertook the Future of Family Medicine Project. The primary objective of that project was to recommend changes to the discipline so that family medicine could better meet the health care needs of its patients in a changing health care environment. As an initial step, a national research study was conducted by independent research firms. This effort produced a wealth of

quantitative and qualitative findings. The formats for this research included: 1) interviews with thought leaders both in and outside of family medicine; 2) interviews with family physicians, payers, advocacy groups, benefits managers, Medicare/Medicaid administrators, nurse practitioners, and patients; 3) focus groups with family physicians, patients across broad demographics, medical subspecialists, managed care/payers, medical students, resident physicians, and nurse practitioners; and 4) a national probability sample of patients, parents of children, family physicians, academic family physicians, non-primary care medical specialists, medical students, and residents in medical training. The conclusion that structuring family medicine office practices into Medical Homes would be the best way to meet the needs of patients in our changing health care environment came directly out of the data from this research.

Meanwhile, a couple of years ago, the Minnesota Academy of Pediatrics partnered with the Minnesota Department of Health to form the Minnesota Medical Home Development Project. As part of that project, 11 different clinics from across the state of Minnesota started to work on the implementation of a system of coordinated care for children, by collaborating with parents as partners in care to develop a care plan for patients that included, among other things, the integration of community resources. These pilot centers are incorporating an ongoing improvement process, based on some of the work of the Institute for Healthcare Improvement, around systems change and performance improvement. As such, each site through practice-based research is gathering data about how to make the Medical Home structure, as originally designed by each office practice, more effective. Data is already accumulating in these pilot centers that is demonstrating better patient outcomes and improved value for the health care system when pediatric practices are structured as a Medical Home.

As stated previously, a Medical Home provides patient-centered care by providing the structure both for long-term relationships and for seamless and timely access to all essential care. There has been a growing body of literature over the last 20 years demonstrating the benefits of patient-centered care provided through a long-term relationship with a personal physician. This evidence can be described as international, national, and local in scope. An example of evidence with an international scope is found in the October 15, 2003, edition of the American Family Physician. There evidence showed that those countries whose healthcare system was structured to provide such an approach to health care had much better health care outcomes at a decreased cost to the system.

There are at least two examples of data with a national scope. One example is provided by Barbara Starfield, MD, Professor of Health Policy & Management at Johns Hopkins, in the March 15, 2005 issue of Health Affairs. She reviewed Medicare data from across the country. The data showed that, when comparing all counties in the US, a 20 percent increase in the number of primary care physicians in any particular county is associated with a 5 percent decrease in mortality within that county. The second example is provided by John Wennberg, MD, out of Dartmouth, who has been able to demonstrate that when patients make choices that truly fit their own personal values, they do in fact make choices that are more cost effective for the system, while providing greater satisfaction and better results for the patient.

Finally, there are at least two examples of data with a local scope. In the Archives of Internal Medicine 2005, volume 165, pages 1749-1755, there is an article by Piette entitled, "The Role of Patient-physician Trust in Moderating Medication Nonadherence due to Cost Pressures," clearly demonstrates the benefits of a trusting relationship with one's own personal physician. In the Annals of Family Medicine 2006, volume 4, pages 69-74, there is an article by Leif Solberg, MD, from Minnesota entitled, "Effect of Improved Primary Care Access on Quality of Depression Care," in which they demonstrate that improved continuity of care by one's personal physician resulted in better compliance with antidepressant medication use.

Thus, there is a growing body of evidence to support that a health care system that is organized around a Medical Home model provides better outcomes and lowers all-cause mortality for patients, while lowering the overall cost of services within the health care system as a whole. A Medical Home supports this physician/patient relationship in a manner that leads to personal trust and responsibility, which has been shown to result in more efficient and effective care provision. We conclude that the data supports the proposition that the Medical Home structure will meet the needs of the Minnesota health care system and the Minnesota economy in the 21st century.