By now, most readers of P&T know that the U.S. health care system has fallen short in its efforts to effectively treat patients with chronic conditions. You’ve heard the drill before: 43% of the population has a chronic medical condition. Among Medicare recipients, the statistics are even worse: 83% have at least one chronic health problem, and almost 25% have at least five comorbidities. Experts across the political spectrum agree that the system of funding for managing chronic diseases is not sustainable.

Perhaps a good place to begin a discussion of health care reform, especially the topic of how to reduce costs associated with chronic conditions, would be the “medical home” model. Paul Keckley, PhD, Executive Director, and Howard Underwood, MD, Senior Manager and Fellow, at The Deloitte Center for Health Solutions, have issued a white paper that rises above the usual rhetoric and goes beyond the lock-step strategies that are usually put forward by member associations within the house of organized medicine.3 This report deserves our attention. I would like to offer my own views on the potential future for the “medical home,” an approach that would include overseeing and coordinating a person’s health care.

As indicated by Dr. Keckley, principal author of the report, Rand Corporation and Dartmouth University researchers had previously revealed that the return on investment (ROI) for reducing the costs associated with unmanaged chronic conditions is potentially very high. Some experts believe that the ROI is so great that it might be sufficient to fund expansion of health insurance (thus increasing access) and to reduce the demand for specialty care and acute-care services (thereby reducing costs). However, the report accurately points out that the incentives to arrest the progression of chronic disease do not exist in today’s health care system. In fact, the current system rewards acute episodic care but does not reimburse care management, active integrated interspecialty management, or even some preventive care services.

Dr. Keckley traces the first mention of the medical home back to the American Academy of Family Practitioners (AAFP) and the American Osteopathic Association (AOA) in issuing joint principles for the Patient-Centered Medical Home (PCMH). By this juncture, then, four major medical groups—AAP, ACP, AAFP, and AOA—had slightly modified the vocabulary and issued white papers supposedly supported by nearly 330,000 physicians throughout the U.S. Still, by February 2007, no concerted efforts, according to the published literature, had documented any real ROI for the infrastructure costs necessary to implement the medical home, as articulated by the four groups that represent organized medicine.

Along came Dr. Keckley with the support of the Deloitte Center. He and his team have done a good job of juxtaposing the current state of affairs with the ideal future situation. For example, the authors characterize the current model of health care as a primary care, physician-centric program whose principal incentive is based on the volume of patient visits. The future model would rest on a primary care clinician, coupled with health care coaches, and a focus on increased patient adherence to self-care regimens. This white paper is the best single summary of the challenges facing the nation as we attempt to implement the PCMH.

After establishing a series of thoughtful economic assumptions based on the peer-reviewed publications and following a detailed review of ROI literature from the disease-management industry, Dr. Keckley and colleagues state that medical homes could more than pay for themselves. Their benefits could also inspire the health care industry to adjust to the task of implementing the new model. They say that “empowering primary care physicians with direct accountability for all care for their patients could help to re-establish the collaborative doctor–patient relationship that the nation has been sorely missing.”

The authors present comprehensive data about the medical home and its implications for key stakeholders, including primary care physicians, multispecialty groups, health plans, employers, and insurers. However, if we are to adopt the medical home model, some challenges remain:

1. Most physicians lack the training and experience to create a medical home; they are usually trained in medicine, not business. Can physicians coordinate health care services more effectively than care-management vendors, health plans, or hospital systems?

2. There might be considerable implications in terms of federal and state government policies. With evidence-based medicine serving as the medical home’s lifeblood, what happens if a physician who is practicing evidence-based medicine still has patients with a poor clinical outcome?

3. The shortage of primary care physicians in the U.S. could delay the development of the medical home.

4. The support structure of the health care industry might be too deficient to facilitate the adoption of the medical home on a large scale.

5. Physicians often lack capital and incentives to take on up-to-date or required information technologies.

6. An increased number of health care

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There you have it. An easy-to-read, thoroughly referenced, and thoughtful report declares the medical home to be cost-effective but also recognizes a market basket full of future obstacles. My hat is off to Dr. Keckley and the entire Deloitte Center team. It’s good to see people from outside organized medicine carry on a dispassionate conversation about the super politically charged and “disruptive technology” of the medical home. It remains to be seen whether corporate America will be convinced about the virtue and economic ROI of the medical home and whether our political leaders have the will to even introduce a sufficient number of test beds for this concept in the near term.

As always, I’m interested in your views. You can reach me at my e-mail address, david.nash@jefferson.edu. My new blog is http://nashhealthpolicy.blogspot.com.

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