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Home, Sweet "Medical Home"

The Veteran's Administration explores an exciting new model of care

If you've been keeping up with healthcare literature, or even reading your local major newspaper, you may have noticed an uptick in references to the "medical home." Some may think that this term is a new invention, perhaps in response to the passage of the Affordable Care Act (ACA), but this is not the case.

The Idea Evolves

The roots of the medical home can be traced back to 1967 when the terminology was first introduced by the American Academy of Pediatrics. At that time, the term was used to describe a central source for all the medical information about a child, especially one with special needs.

In 1992, the American Academy of Pediatrics issued a policy statement that was influenced by Dr. Calvin C.J. Sia, a Honolulu-based pediatrician who pursued new approaches to improving early childhood development in Hawaii in the 1980s. The Academy policy statement defined the medical home pretty much the way Dr. Sia had described it, which was a strategy for delivering the family-centered, comprehensive, continuous and coordinated care to infants and children.

In 2002, seven U.S. organizations created the Future of Family Medicine Project, further expanding the definition of the medical home with the goal to "transform and renew the specialty of family medicine." The project recommended that every American should have a personal medical home through which he/she would receive their acute, chronic and preventive services. The study also recommended that these services should be "accessible, accountable, comprehensive, integrated, patient-centered, safe, scientifically valid, and satisfying to both patients and their physicians."

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The above sounds like a healthcare environment that many nurses would describe as being optimal for the delivery of high-quality care. Indeed, the fundamentals of the medical home fall squarely in our nursing bailiwick.

Win-Win

A study published in the November 2004 issue of the *Annals of Family Medicine* estimated that if the Future of Family Medicine recommendations were followed (including the implementation of personal medical homes), healthcare costs would likely decrease by 5.6 percent, resulting in a national savings of $67 billion per year. The report concluded that in addition to the savings there would also be an improvement in the quality of the healthcare provided.

In 2007, the Joint Principles of the Patient-Center Medical Home were released by the largest primary care physician organizations in the United States.

VHA Medical Home

Not that long ago I had the opportunity to speak with a nursing colleague who had accepted a position with the Veteran's Health Administration (VHA) in her community. It just so happened that she would be in charge of the VHA Patient Centered Medical Home (PCMH).

In her new position she'd be a member of a multi-disciplinary healthcare team which included the veteran patient, his/her provider, an RN care manager, a clinical staff assistant and an administrative staff member. To coordinate seamless care, all members of this core team collaborate with other medical and support staff, including non-VHA healthcare providers, to meet the needs of the veteran patient.

In addition to medical issues, concerns that are addressed include clinic hours, parking, transportation, telephones, staff etiquette and so forth. The members of the team organize focus groups or patient advocacy boards to get feedback, advice and to provide guidance.

A Common-Sense Approach

She shared with me some patient management tools and techniques that were unique to the PCMH. They include mandates to:

• Delegate tasks

Nurses are reminded that they don't need to do everything themselves (what a nice change!). For example,

they could utilize the services of the pharmacist to manage anticoagulation and other conditions that require medication monitoring and titration, such as hyperlipidemia and diabetes.

• Increase revisit intervals

There were no set rules on scheduling return visits, so pushing them back by just a few weeks is a huge benefit. For example, the VHA average is 2.34 visits a year per patient. This equates to 2,350 visits for a panel of 1,000 patients. Pushing that back only two weeks makes the return visit rate 2.15 times a year, which equates to 2,150. This in turn frees up 200 slots a year or almost one slot a day.

• Scrub the schedule

Patients sometimes call in for an appointment they may not really need. For example, a prescription refill or a form filled out. A nurse can look at the list of patients scheduled during the upcoming week, review the charts, and give them a call. They might be happy to eliminate a trip to the clinic. The Navy's medical home in Bethesda, MD, assigned a nurse to this task and found they could eliminate about 30 percent of their scheduled appointments.

• Be flexible

Scheduling patients when it's convenient for them to come in reduces no-shows significantly — imagine that! Filling the schedule with appointments made way in advance is just asking for trouble. If patients know they can see you when they need to, they're less likely to schedule an appointment "just in case."

• Schedule group visits

Many of the PCMH patients may share similar conditions and characteristics, and for some, coming to the clinic may be as much as a social event as a clinical one. So setting up group visits for patients with similar diagnoses, such as diabetes or hypertension, may provide patient education and mutual support.

The Seven Key Principles of the VA Medical Home

1. **Patient-Driven** — the primary care team is focused on the whole person. Patient preferences guide the care provided.
2. **Team-Based** — the primary care provider uses facilitative leadership skills to lead an interdisciplinary team.
3. **Efficient** — Veterans receive the care they need at the time they need it from an interdisciplinary team functioning at the highest level of their competency.
4. **Comprehensive** — primary care serves as a point of first contact for a broad range of medical, behavioral and psychosocial needs that are fully integrated with other VHA health services and community resources.
5. **Continuous** — every patient has an established and continuous relationship with a personal primary care provider.
6. **Communication** — the communication between the Veteran patient and other team members is honest, respectful, reliable and culturally sensitive.
7. **Coordinated** — the PCMH team coordinates care for the patient across and between the healthcare systems, including the private sector.

We've come a long way in our medical treatment of those in uniform. Above is a National Archives photo of a "hospital" in Gettysburg in 1863 where an amputation is about to be performed.

Home At Last

As my friend described her interaction with members of the team and the patients I could see how energized she had become. A veteran herself, I noticed a more distinct spring in her step and a gleam in her eye, as she recounted to me her experiences with the VHA PCMH. It was as if she had found her niche, her forever nursing job so to speak — the kind that we all hope to have sometime during our nursing career.

As the mother of a veteran, I was happy to learn that the VHA had developed such a model of care. I can only hope that my son has a PCMH in his community. Perhaps this model will eventually be replicated throughout our healthcare system, because everyone deserves a good home. WN

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