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PERSONAL HEALTH

## A Personal, Coordinated Approach to Care

By JANE E. BRODY

To the Odom family of Durham, N.C., Dr. Gloria M. Trujillo is a savior. Johnny Odom, at 57, has congestive heart failure, diabetes, kidney failure, high blood pressure, gout, high cholesterol and blindness in one eye. His daughter, Tonia, 35, has rheumatoid arthritis, and her 10-year-old son has asthma, a seizure disorder, high blood pressure, prediabetes and sleep apnea.

Dr. Trujillo, a primary care physician at the Family Medicine Center at Duke University, takes care of them all, coordinating the care they receive from various specialists via electronic records and e-mail. Ms. Odom uses the clinic's online health portal to get the family's medical information, make appointments and check the lab results Dr. Trujillo sends her.

Ms. Odom is especially pleased with the time the doctor takes to explain their medical problems and motivate her son to walk every day, which helps him maintain his weight and lower his blood pressure so he no longer needs medication.

At the same time, the extraordinary care the family receives, which is financed by Medicare and Medicaid, saves money by preventing medical complications and keeping the Odoms out of the hospital.

The Duke clinic represents a promising approach to delivering better health care: the so-called medical home. As President Obama and Congress try to create a national system that provides better care for more people at lower cost, you are likely to hear a lot more about this idea.

The term, coined by the American Academy of Pediatrics in 1967, is admittedly confusing. It does not mean a return to house calls. Nor need it apply only to people with complex health problems like those of the Odom family.

Rather, it is an approach in which each person has a primary care doctor who heads a team of professionals — perhaps including a physician assistant, a nurse practitioner, a dietitian, a social worker and a pharmacist — to provide round-the-clock access to care.

It is unlike managed care, in which primary doctors act as gatekeepers to specialists and the overriding goal is not managing care but managing costs. In a medical home, the family doctor helps patients get specialty care when they need it and, through electronic records, keeps careful track of treatments and informs specialists of the patients' progress. The connections between the professionals who work on each case are seamless and convenient. Doctors and patients have easy access to medical information, and patients with chronic ailments are called regularly to reinforce treatment regimens and see how they are doing.

"I love this clinic," Ms. Odom told me in an interview. "Everyone's so friendly and knows you by your first name. I

never have to wait more than a few minutes, and there's a board that tells you how long the wait is."

She added: "I feel really cared for. If my arthritis flares up, someone gets back to me the same day with the prescription I need. Dr. T taught us about heart failure and how to recognize danger signs so I know when to get my father to the emergency room."

### **Focus on Prevention**

There are now medical homes in more than a dozen states, many of them serving Medicaid patients. Their proponents say they save money because they focus on prevention and prompt attention to emerging problems, which can prevent costly complications. Some major health insurers are also testing patient-centered medical homes.

Medicare, until recently a holdout, now has a medical home demonstration project under way. If successful, it could have two huge benefits: it could help the Medicare system remain solvent as the older population grows, and it could result in coordinated care that emphasizes wellness rather than a fragmented, difficult-to-navigate system based on costly acute care.

An 81-year-old friend with multiple health problems complained recently that she was seeing an orthopedist, a rheumatologist, an oncologist, an ophthalmologist and an endocrinologist but had no doctor to oversee and coordinate her overall care.

The medical home concept has won the support of the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association, among others. Bipartisan legislation in Congress would support medical homes in the Medicaid and children's health insurance programs, which are jointly financed by the states and the federal government.

In The Journal of the American Medical Association last month, Dr. Diane R. Rittenhouse, a family and community medicine specialist at the University of California, San Francisco, and Stephen M. Shortell, dean of the School of Public Health at the University of California, Berkeley, wrote that in a patient-centered medical home, care was tailored "to meet the needs and preferences of patients." Rather than passive recipients, patients would be "more active, prepared and knowledgeable participants in their care."

Having a continuous healing relationship with a personal physician has been shown in a review of 40 studies to significantly improve health outcomes.

### **The Whole Patient**

Another virtue of the medical home is an emphasis on the whole patient and the patient's environment, rather than a specific disease or body part. Patients, doctors and families work together to make health care more effective and reduce its costs.

Dr. Atul Grover, an assistant vice president of the Association of American Medical Colleges, said in an interview that the medical home approach could revitalize student interest in primary care, which has been hemorrhaging doctors as their workloads increase and incomes and professional satisfaction shrink relative to those of specialists like cardiologists and orthopedists.

"The incentives in our current payment system are at odds with efforts to increase our focus on prevention, disease

management and other aspects of patient-centered care,” Dr. Grover said. “Procedures are often reimbursed at a much higher level than cognitive services.

“If a physician spends 10 minutes intubating a patient in a hospital, that physician may be reimbursed more than a physician who spent twice as much time taking a patient history and creating a treatment plan.”

Dr. Shortell said the medical home concept required a new payment system, like “a single payment for both doctors and hospitals that gives them an incentive to work together to keep patients well.” Electronic health records, vital to the effectiveness of a medical home, are especially useful in rural areas where practitioners can be connected in a “virtual medical home,” Dr. Shortell said.

Dr. J. Lloyd Michener, chairman of community and family medicine at Duke, said that in the future, “we will have to train doctors to be members of teams — both within the office, where people are seen before they get sick, and within the community, to help create healthier environments.”

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