Home-Centered Health Care

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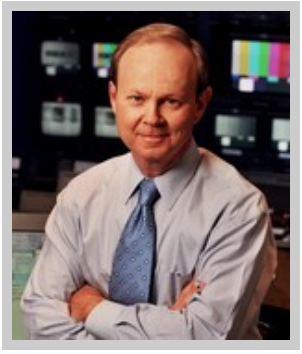
Congressional Testimony: Home-Centered Health Care by Mike Magee, MD



Mike Magee, MD

As a health policy professional and weekly media commentator on health care issues, I am often asked for my opinion on where our health care system is headed. I have the advantage of being able to share perspectives with a wide range of thinkers in the health care arena, and their opinions on what needs to be done about our health care system cover the entire spectrum of possibilities. Clearly, there is no single perfect set of answers. Nor is there enough time allotted today to discuss all the possible scenarios for the future as they relate to the many issues that challenge our current system -from health insurance reform to end-of-life care.

Still, I think the diverse dots that make up the current thinking in health care can be connected, and that a new vision is beginning to emerge. After more than 30 years of observing health care and thinking about what's possible, let me lay out what I believe are several general factors and trends that are defining our health care future, and what I believe is the most likely destination they are taking us toward, a new paradigm of care I call "home-centered health care". (1)

The first, and most important factor is that we are aging as a society. We must acknowledge that this demographic change will profoundly impact health care as we know it today. Part of that change involves moving from the typical three-generation American family to four- and five-generation family complexity.(2) This means that the typical American middle-aged person can expect to be managing parents and grandparents above them, while managing children and grandchildren below. Faced with a complex health care system and a multi-generation family burdened with high levels of chronic disease, many of these

middle-aged Americans have joined a vast population of informal family caregivers (now present in 25 percent of American families). They are poorly supported, self-educated, motivated, and involved with complex clinical and financial health care decisions. They represent a populist force that increasingly questions the status quo.(3)

Recognizing this rising force and the changing dynamics of the patient-physician relationship, physicians, nurses and other formal caregivers have moved from away from paternalism toward partnership, and are moving from individual to team-support models.(4) As they do so, they are realizing that the Medical Infrastructure is not ideally suited for the demands our aging society will place on the health care system, let alone the generations below. There is, simply put, no reimbursment and minimal time and space left in the doctors' offices for preventive care. Our outpatient office-based delivery system is not ideally suited for the rigors of the future.(5)

Combined, these forces point the system toward a logical solution: Properly supported and validated by physicians and nurses with education, coaching, behavioral modification, early diagnosis and screening, and virtual connectivity, most care decisions and care functions should increasingly take place in the home. (6)

I believe this concept of home-centered health care will grow rapidly in coming years, and it will lead to the transformation of informal caregivers into designated home health managers, and to their inclusion more formally into the physician-led, often nurse-directed health care team. In this new paradigm, health care teams will work with individuals and families to coordinate both clinical, educational, and planning continuums under physician oversight. Most educational leadership will be delegated by physicians to nurses and other caring professionals who will maintain 24/7-contact with home health managers through virtual health networks.

For this model to succeed, HIT efforts must be reoriented from their current physician-hospital focus to one that is anchored around the patient-physician connection. Information generated by the patient should be easily captured, stored and transferred to his/her personal care team. Personal Health Records (PHRs) may prove to be a central element of this system as it provides a storage system for patient information. (7) Physicians and nurses must in turn have access to technology that will receive, record and monitor this information as well as provide evidence-based decision support. The establishment of this bi-directional flow of information is one of the highest priorities of this model. Internet access via home computers and wireless mobile technologies will be

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critical, however not entirely necessary. Some key elements can be accomplished via basic telephone connections. Scalability however quickly becomes an issue when limited to basic telephone services.

The virtual health networks will be here soon, thanks to incredible advances in technology. Visionary thinkers in health care technology-ranging from corporate giants such as Intel and Philips Inc. to small, entrepreneurial start-ups-are working today below the radar screen on amazing devices that will revolutionize care and make true networks possible.(8) Those applications will advantage our expanding information highways, built on the backs of digital cable and wireless WiMax installations, which are now reaching the critical mass necessary to connect the people to the people caring for the people.(9) (10)

The current surge of private technology investment in home health will outfit homes with pervasive motion/location sensors, vital signs monitoring, blood and imaging diagnostics, intelligence analytic software, personalized prompter coaching interfaces, and Internet data transfer to care networks-functionally bringing the virtual care team and its resources into the home and obviating the need for most office visits and many hospitalizations. (11)

As technology and demographics lead us inexorably toward this new paradigm, the health care financing system will be forced to keep pace. (12)Health insurance will go universal, be portable, and involve multi-year commitments. Health insurers will reimburse physicians fairly for management of teams and oversight of complex databases and will offer incentives for home health managers by providing lower premiums to families who deliver measurably positive health outcomes , effective lifespan planning, prevention and screening across the multi-generation family divide.

Pharmaceutical and device companies will invest in consumer education and behavioral modification, early diagnosis and prevention, and a new business model built around home-centered health solutions. Health information highways will be home-centric; that is, begin in the home, extend out to the caregivers, and loop back to the home, rather than the other way around. A continuous robust stream of data will flow out electronically, and 24/7 analysis and coaching will flow back in, in the other direction.(13)

At the end of the day, caring will re-center in the home, where compassion and personalization reside. Here, caring will integrate mind, body, and spirit; focus on wellness and functionality; integrate and prioritize resources along the four- or five-generation family divide; and tailor care to the unique cultural and social needs of family members. On the one hand, adherence to mutually agreed-upon

care plans will better manage chronic diseases using the principles of palliative care. On the other, lifespan planning records will attempt to get ahead of the disease curve and delay or completely eliminate chronic disease in future generations. (14)

Thanks to recent scientific advances including genomics, we are beginning to identify and validate predictive biomarkers. This will allow accurate baseline risk assessment, disease tracking, prediction of future clinical events and appropriate preventive therapeutic steps. In short, science is now, or soon will be in a position to make careful lifespan health planning and patient adherence to agreed upon plans well worth the sacrifice and effort. (7) Attempts to stay well will effectively pay-off in real time, and in the future must be rewarded financially through realigned incentives tied to evidence based outcome measures. In response, patient, families and communities will be happier and more productive, and the cost of disease will begin to decline. (12) Physicians, nurses, and other members of the care teams will advocate for these changes because they make sense and are the only reasonable way to manage the cost and quality demands of global aging societies. Homes will look to their communities for value grounding, integrated social systems, and resources if overwhelmed by complexity.

We might think of the coming transition in health care as a kind of populist uprising-led by consumers who now possess the critical combination of enlightenment, empowerment, connectivity, computing power and personal motivation needed to assert control over their own health care futures.

Much work remains to be done before this vision of health care will be fully embraced including realignment of financing, inclusion of new sector participants, advancing universal coverage and access, privacy protections, targeting vulnerable populations for early intervention and addressing issues of licensure and liability coverage.(15) And there will be resistance. Some sectors of our health care system continue to cling to the silos of yesterday, believing the health space to be segregated from the rest of our lives. But if trends continue to play out as they have recently, the keepers of the silos will soon face head on the force of millions of consumers who demand change. Those consumers will be reinforced by financial, technology, and entertainment sectors anxious to enter the health care space and sharing three strategic resources-vast financial assets, remarkable expertise in information technologies, and a well-established position already in consumers homes. (16)

There are then ten core elements of the vision of home-centered health care that will guide this public-private enterprise:

1. A home health manager has been identified by each extended family.
2. A medical information highway has been built primarily around the patient with caregivers integrated in, rather than the other way around.
3. The majority of prevention, behavioral modification, monitoring and treatment of chronic diseases now takes place in the home.
4. Physician-led, nurse-directed virtual health networks include informal home health managers and provide a community based, 24/7 clinical, educational and emotional support team.
5. Health insurance covers nearly all Americans and premiums for families have gone down due to home health managers ability to drive better outcomes.
6. Basic diagnostics, including blood work, imaging, vital signs and therapeutics are preformed by individuals and home health manager and are transmitted wirelessly and electronically to physician/nurse teams which provide feedback loop coaching and treatment options.
7. Sophisticated behavioral modification tools and customized search engine targeted personal research and information support is present and utilized, supported by diagnostic and therapeutic companies, and built with direct creative input from technology, entertainment and financial sectors. In the process, health care moves from information to strategic planning.
8. Physician office capacity has grown since most care does not require a visit. Physicians and nurses in general are more available and more mobile. Physician reimbursement has increased to fairly reflect their roles in managing these mutli-disciplinary care teams. The role of education director of home health networks has been boom to RN's, whose numbers have markedly increased nationwide.
9. Concentration on ages zero to three and early brain devlopment have reinforced active parenting and early nurturing; family nutrition is carefully planned and executed; activity levels of all generations are up; weight is down; cognition is up.
10. Hospitals continue to right size and become more specialized and safer.

The merits of the home-centered health care model are obvious and well aligned with the Institute of Medicine (IOM) framework for health system reform laid out in its' 2001 Crossing the Quality Chasm: A New Health System for the 21st Century report. It successfully accomplishes the key imperatives laid out in that report and follows the 10 rules for redesign (17).

1. It builds out a care model that is based on continuous health relationships.

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2. Care is customized to patient needs & values. This is made possible by analyzing the continuous stream of home-generated medical data and by the engagement of both the patient and the home health manager.
3. The patient is the source of control.
4. Knowledge is shared and information flows freely between the patient and the care teams.
5. Decision making is evidence-based.
6. Safety is a system property. Easy access to patient data, better coordination of information, and the oversight of a home health manager will help ensure medical errors are minimized.
7. Transparency is necessary and enabled by the bi-directional information flow.
8. Needs are anticipated as a result of monitoring patient activities and medical data. Ideally this will result in interventions that will support prevention, and where appropriate earlier diagnoses.
9. Waste is continuously decreased. The system should not waste resources or patient time.
10. Cooperation among clinicians is a priority.

If such efforts are successful, they will result in the six key outcomes which Don Berwick summarizes as the following (18):

1. Safety: Patients ought to be as safe in health care facilities as they are in their own homes.
2. Effectiveness: The health care system should match care to science, avoiding both over use of ineffective care and under use of effective care.
3. Patient- centeredness: Health care should honor the individual patient, respecting the patient's choices, culture, social context, and specific needs.
4. Timeliness: Care should continually reduce waiting times and delays for both patients and those who give care.
5. Efficiency: The reduction of waste and, thereby, the reduction of the total cost of care should be never-ending, including, for example, waste of supplies, equipment, space, capital, ideas, and human spirit.
6. Equity: The system should seek to close racial and ethnic gaps in health status.

In summary, the health care needs of a 21st Century America can no longer be adequately served by a health care system that originated over a century ago.

Science and society have made enormous advances over this period. Most notably, we now have the knowledge and tools to not only move away from intervention, but also to move toward strategic health planning and universal health care coverage. (19) But to do so, traditional health care leaders must embrace new partners, listen to the people and follow their lead-for after all, it's their health and their health care system. Why not strive for excellence in both?

Mike Magee, MD is Editor of Healthcommentary.org.

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