AADE Practice Advisory

Medical Home and Its Importance for the Diabetes Educator

The Medical Home concept (aka patient-centered care) aims to provide accessible, continuous, coordinated and comprehensive patient-centered care. Such care is managed by a primary care physician with the active involvement of a team comprising other medical professionals and practice staff. Some payors offer supplemental payments to providers that are deemed to be a medical home in recognition of the coordinating role that they play. While the evidence for the Medical Home continues to emerge and some studies are underway, the concept is gaining popularity among policy makers.

Diabetes educators are essential to effective self-management of diabetes and related behavior change and overlap and interface with other providers on the care team. Diabetes self-management education and training (DSME/T) plays an essential role in the management of diabetes. DSME/T serves as the first line of defense in preventing costly and debilitating conditions, including cardiovascular disease, kidney failure, blindness and lower limb amputations. It also helps prevent emergency room visits related to acute complications such as low or high blood sugar reactions. Diabetes educators provide DSME/T and as such, facilitate physicians' ability to provide comprehensive care.

Background:

Major payors (public and private) and major healthcare purchasers have been persuaded that the most effective health care systems are centered in primary care. The literature on medical homes shows superior outcomes for large primary care practices but there is a gap in information about the value of the concept in small or specialty practices.

In 2008, the American Academy of Family Physicians stated: "A patient-centered medical home integrates patients as active participants in their own health and well-being. Patients are cared for by a physician who leads the medical team that coordinates all aspects of preventive, acute and chronic needs of patients using the best available evidence and appropriate technology. These relationships offer patients comfort, convenience, and optimal health throughout their lifetimes."

In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association released the following "Joint Principles of the Patient-Centered Medical Home."

- **Personal physician**: "each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care."
- **Physician directed medical practice**: "the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients."
- **Whole person orientation**: "the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals."
- **Care is coordinated and/or integrated**, for example, across specialists, hospitals, home health agencies, and nursing homes.
- **Quality and safety** are assured by a care planning process, evidence-based medicine, clinical decision-support tools, performance measurement, active participation of patients in decision-making, information technology, a voluntary recognition process, quality improvement activities, and other measures.
- **Enhanced access** to care is available (e.g., via "open scheduling, expanded hours and new options for communication").
- **Payment** must "appropriately recognize[s] the added value provided to patients who have a patient-centered medical home." For instance, payment should reflect the value of "work that falls outside of the face-to-face visit," should "support adoption and use of health information technology for quality improvement," and should "recognize case mix differences in the patient population being treated within the practice."

The Medical Home could permit more purposeful and planned team functions that support a sustained relationship with patients. On the other side of this is the discussion whether the Medical Home has the ability to deliver the quality care, coordination and reduction of healthcare costs and utilization that the advocates of the model are promising. Some of these concerns are directly related to whether this can be accomplished in a system with so few primary care physicians, physician extenders like diabetes educators and a lack of technological resources to allow the Medical Home to succeed on a national level.

AADE American Association of Diabetes Educators

Role of the Diabetes Educator

Diabetes educators are important members of the care team and provide evidence-based, patient-centered care to people with diabetes. Educators help the physician implement and carry out the care plan. As the Medical Home discussions continue, it is important that the diabetes educator:

- Be included as a key member of the medical home team.
- Develops a working knowledge of the Medical Home model concept.
- Articulate and demonstrate the important contribution that educators can and should make as part of the medical home care team.
- Helps people with diabetes and their caregivers to understand the medical home concept and how the diabetes educator is an essential member of the care team.
- Add to the evidence base by conducting research and evaluation on the on the importance of the diabetes educator in the medical home.

Supplemental Information

American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA). Joint Principles of the Patient-Centered Care. 2007. http://www.medicalhomeinfo.org/joint%20Statement.pdf

AAMC. AAMC Adopts Position on "Medical Home" System of Care Coordinated Care Approach May Improve Health Care Outcomes. 2008. http://www.aamc.org/newsroom/pressrel/2008/080325.htm

AARP. Finding Your Way: Coordinating Your Care Through a Medical Home. 2009. http://bulletin.aarp.org/yourhealth/healthyliving/articles/finding_your_way_coordinating_your_care_through_a_medical_home.html?CMP=KNC-3601-GOOGLE-BULL&HBX_OU=50&HBX_PK=medical_home

Patient-Centered Primary Care Collaboratives. 2009. http://pcpcc.net/