FROM THE EDITORS' DESK

Innovation and Inauguration

Malathi Srinivasan, MD

Division of General Internal Medicine, Department of Medicine, Davis School of Medicine, University of California, Sacramento, CA, USA.

J Gen Intern Med 28(1):1–2
DOI: 10.1007/s11606-012-2263-6

As the time of this writing, the United States presidential election is less than 30 days away. Rhetoric is running high about national policy issues, ranging from immigration policy to healthcare reform. Whether one was influenced by the policy stances of the presidential candidates, the Romney–Obama debates, or the Jon Stewart–Bill O'Reilly face-off, the stakes for national healthcare policy could not be higher.

Keen observers of health policy are aware of the magnitude of what's at issue: The health of the nation is imperiled, with growing obesity, chronic disease and an aging population. The healthcare safety net is fragmented, and the "have–have not" divide grows wider. Health care expenditures in 2010 (the last set of National Health Expenditure Accounts, Centers for Medicare & Medicaid Services [CMS], January 2012) was close to $2.6 trillion, with a current gross domestic product of $15.6 trillion for a population of 315 million individuals (US Department of Commerce, Sept-Oct 2012). As Bodenheimer has pointed out, healthy individuals account for only 3% of total health costs, while 10% of the population accounts for 70% of national health expenditures.

Yet, there may be some room for optimism about the financial health of the nation's healthcare. Over the past 2 years, the healthcare cost curve seems to have tilted downward, with excess growth reduced by 1% in 2011 in Roerhig's latest analysis. This downward trend may be due to cyclic factors (recession with decreased insured individuals) or structural factors (changing physician practice and employment patterns, patient cost-sharing, stable insurance premiums, patent expiration and generic medication use). Additionally, new care models and novel partnerships may also contribute to cost-savings, promoting health and increasing care coordination.

This month in *JGIM*, we explore a series of innovations, and their implications for patient care. Mitchell and colleagues[1] evaluate a public–private partnership around health—a collaboration between Tennessee Medicaid and Weight Watchers, in which 1,605 individuals were enrolled in a weight management program, with 20% losing over 5% of their original weight. As Bleich and Herring[2] discuss in the accompanying editorial, the cost to Medicaid was a nominal $19 for an introductory session, and $11 for follow-up sessions, with patient co-pays of $1. Such programs are as cost-effective as bariatric surgery, and more cost-effective than medication management. Next, Schnurr and colleagues[3] remind us that care interventions need to be sufficiently potent and durable to move the health care outcomes needle. In a randomized trial of 195 veterans with post-traumatic stress disorder (PTSD) at four Veterans Affairs facilities, patients with telephone care management (in addition to usual care) had more mental health visits and were more likely to fill prescriptions, but experienced no differences in symptoms or functioning. Howard's[4] study also cautions policy-makers to think closely about the implications of electronic health record (EHR) implementation. In her study of small community-based primary care practices, she found physician's workload increased during EHR charting and patient-care tasks, while support staff work and patient flow improved.

Several articles in this issue explore issues around the National Committee for Quality Assurance's Patient Centered Medical Home (PCMH) Initiative. In an ideal setting, the well-implemented PCMH involves re-organizing medical care around the patient experience; includes a set of standards (linked to increased federal funding) that track, coordinate and report patient outcomes over time; connects patients to a personal physician; and improves inter-professional collaboration and team-based care. The article by Braddock and colleagues[5] explores the ethical dimensions of the PCMH, including their strengths and limitations, viewed through the lens of Beauchamps and Childress' principles of medical ethics: respect for autonomy, beneficence, justice and non-maleficence. In their accompanying editorial, Wynia and Sabin[6] extend Braddock et al.'s argument to explore issues around the practical implementation of these ethical principles and how current medical culture may promote or inhibit acceptance of PCMH concepts. Work by Alexander and colleagues[7] reinforces the need for practical touchstones around PCMH implementation. They conducted a series of semi-structured interviews with representatives from physician organizations and primary care practices who were in the process of pursuing PCMH designation. They found that provider motivation to adopt PCMH measures were heavily influenced by perceived administrative burden, misalignment of reimbursement schemas, perceptions of control over their working environment, and uncertainty of healthcare reforms.

Published online December 15, 2012

By the time you read this piece, the next US president will have been chosen. If President Obama is re-elected, his administration will face the challenge of implementing the broad reforms outlined in the Affordable Care Act. If Governor Romney is the people's choice, he will have to decide what to preserve and what to dismantle. Either way, solid research, including careful evaluation of "innovations" that may or may not work as promised, will be needed to light the way forward. We would like to think that some of that work will be published in JGIM.

Corresponding Author: *Malathi Srinivasan, MD; Division of General Internal Medicine, Department of Medicine, Davis School of Medicine, University of California, 4150 V. Street, Suite 2400, Sacramento, CA 95817, USA (e-mail: malathi@ucdavis.edu).*

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