BY WILLIAM G. WILKOFF, M.D.

LETTERS FROM MAINE

Home, Sweet Home

That steady buzzing sound bugging me for the last couple of years has finally gotten so loud that I must write about the two words that are causing all the noise: Medical Home. How could one possibly argue with a concept that has such a nice apple-pie-and-motherhood ring to it?

The term was actually introduced by the American Academy of Pediatrics in 1967 before many of its active members were even born. Originally, "medical home" referred to the notion of archiving a child's medical record in a central location. Most children from traditional families now have what might be called a loosely centralized medical record, including reports from consultants and other providers, housed in the pediatrician's office.

In 2002, buoyed by this very modest success, the AAP expanded the concept to include more attributes of good care such as accessibility, continuity, comprehensiveness, and compassion. They also recommended that a medical home be family centered and culturally effective. With the exception of comprehensiveness, adopting these operational characteristics should be well within the reach of nearly every pediatrician regardless of the size or financial health of his or her practice. For some physicians, meeting this vision of a medical home may require some attitude adjustment about availability, but the upside is that these changes are likely to make their practices more attractive to consumers.

By 2007, the neighborhood around the medical home had become so attractive that the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association joined the AAP in claiming ownership and generated a document titled "Joint Principles of the Patient-Centered Medical Home." This two-page document significantly expands the concept of a medical home, draping it with wordy garlands such as "physician directed," "patient-centered," "whole person orientation," and "evidence-based."

The new principles lean heavily on expensive improvements in information technology and quality assessment. Here is where there is more than a little devil lurking in the details, because I'm not confident that an electronic health record system exists that is up to the task as envisioned in these principles at any price.

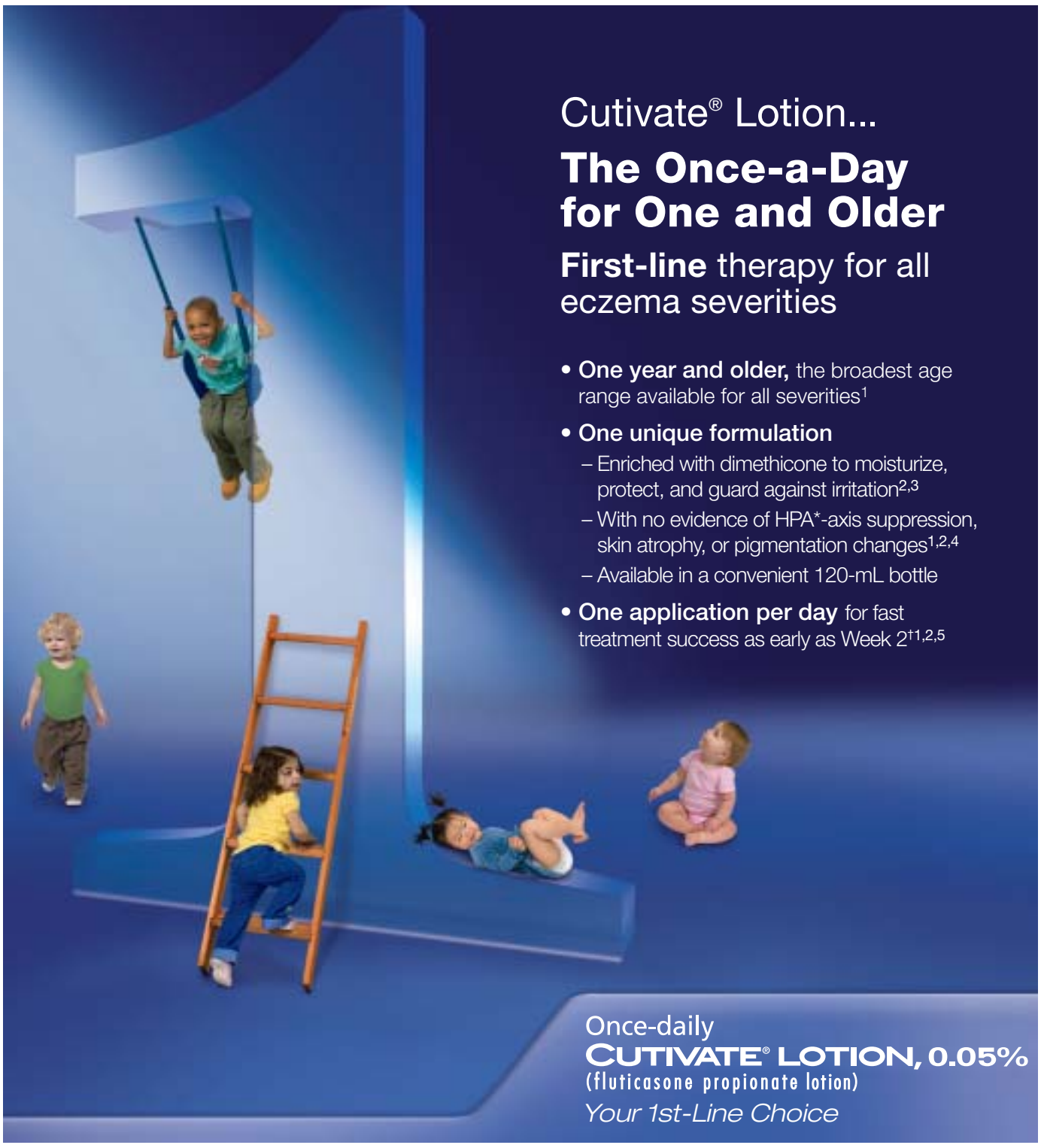
Small practices like ours also can't generate enough data to allow for valid comparisons and conclusions. When our small group went looking for a system that would permit the data crunching and sharing that is necessary for quality improvement studies, we found that most of the users weren't as happy as we were with our old homegrown system. To make matters worse, sharing data requires that our computer system must be willing to talk with the other systems in our neighborhood. That degree of uniformity doesn't seem to exist yet.

Small practices also have much more difficulty providing the comprehensive services suggested in the advanced guidelines. For example, even if we had the room in our medical home for mental health providers, there aren't any around because they abandoned our neighborhood several years ago.

Although the term "medical home" has a nice "Little House on the Prairie" feel, the concept has morphed into one that favors larger, wealthier, and more highly structured practices. For us small players, return to a more modest definition makes the most sense.

How about, "The medical home, the first place to call for all of your child's health problems"? This may sound a little like the old "gatekeeper" mantra. But, the key difference is that instead of a family being forced to call to obtain access to the system, the availability, quality, and compassion of the medical home should make the decision of where to call an obvious one. ■

DR. WILKOFF *practices general pediatrics in a multispecialty group practice in Brunswick, Maine. Write to Dr. Wilkoff at our editorial offices (pdnews@elsevier.com).*



*HPA = hypothalamic-pituitary-adrenal.

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References: 1. Cutivate® Lotion, 0.05% [prescribing information]. Melville, NY: PharmaDerm®, a division of Nycomed US Inc. 2008. **2.** Eichenfield LF, Miller BH; Cutivate Lotion Study Group. Two randomized, double-blind, placebo-controlled studies of fluticasone propionate lotion 0.05% for the treatment of atopic dermatitis in subjects from 3 months of age. *J Am Acad Dermatol.* 2006;54:715-717. **3.** Uliasz A, Lebwohl M. Dimethicone as a protective ingredient in topical medications. Poster presented at: 65th Annual Meeting of the American Academy of Dermatology; February 2-6, 2007; Washington, DC. **4.** Hebert AA, Friedlander SF, Allen DB; Fluticasone Pediatrics Safety Study Group. Topical fluticasone propionate lotion does not cause HPA axis suppression. *J Pediatr.* 2006;149:378-382. **5.** Data on file, PharmaDerm.

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