Health Policy in Medicine: Inside the Beltway

Assessing the Medical Home: Premium Investment or Sub-Prime Mortgage?

by Eugene Rich, MD, FACP

August 1, 2009

Over the past two years health policy makers and health care payers have expressed increasing awareness of the woeful state of primary medical care in the US. The 20th Century saw the dramatic rise of the medical and surgical specialties and the term primary care was articulated to clarify the unique role of generalist clinicians in the health system. In most other industrialized countries general physicians are the foundation of the medical care system, accountable to their patients for providing accessible, patient centered, continuous, coordinated, and comprehensive care. In contrast, US societal investments in primary care have been in a protracted, 50 year decline, and in 2008 US medical student interest in this role reached new lows. Numerous studies confirm that at the very time when high access to comprehensive and coordinated care is most needed in the US, these medical care functions are nearing collapse. What to do?

Recognizing these new challenges (as well as new expertise and technology such as health information technology and case management), health reform experts have developed the concept of the “Medical Home.” In this form of enhanced primary care, old fashioned Marcus Welby, MD, is replaced by a 21st Century version (more like Dr Beverly Crusher of the Starship Enterprise), a generalist clinician expert assisted by advanced technology, powerful information systems and a highly coordinated team of professional colleagues. This “Patient Centered Medical Home”* is characterized by patients having an ongoing relationship with a personal physician (or nurse practitioner) trained to provide first contact, continuous and comprehensive care in a medical practice where a team of individuals collectively take responsibility for ongoing, whole-person oriented health care. In the Medical Home, care is coordinated and integrated across all elements of the health care system, with emphasis on quality, safety, enhanced access (including expanded hours and electronic communication) Health plan funded demonstrations are starting in various communities and even Medicare is about to get in to the act. Inside the DC beltway (“65 miles surrounded by reality”) the Medical Home looks like it’s being built on a solid foundation.

Many potential buyers of the medical home are skittish, however, as revealed at a recent DC-based Medical Home Policy Conference I helped lead. Payment analysts ask difficult ‘real world” questions: “How do we tell what’s really a medical home? Who should get which medical home services (doesn’t the frail diabetic with kidney failure need more medical home services than the robust 65 year old jogger)? How do we tell if those extra services were actually delivered? How do we make sure we aren’t just paying more for the same old care? What clinicians do we designate as medical homes?” (Many remember the 90’s arguments when even anesthesiologists and neurosurgeons were claiming the status of primary care physician).

Patients who learn about the medical home in focus groups are confused and nervous; some fear this is a return to the much reviled “primary care gatekeeper.” Others think of nursing homes (not their ideal of personalized health care) or big clinic buildings that are neither readily accessible nor user-friendly. While patients are frustrated with the costs, confusion and inconvenience of our fragmented health care system, few have had a sustained experience with a high functioning primary care practice and wonder if a “medical home” is something they want to invest in.

And many practicing generalist physicians remain highly skeptical. Angry over the problematic trajectory of primary care fee payments (especially for Medicare and Medicaid), the threats of health plan “report cards,” and the burdens of various P4P initiatives, they often view payment innovations with hostility. And as they look at the details of medical home proposals, they ask many questions: “If I’m the “coordinator” do I have to hunt down reports from consultants- why aren’t they required to coordinate with me? Am I just going to be a manager of other professionals (like PA’s or NP’s) with no personal relationship with my patients? Isn’t this just another way of shifting money to big groups and specialists who can afford the paperwork, the electronic technology, and the extra staff?”

These reactions are understandable; the recent history of US health policy has included many boondoggles. Winston Churchill famously observed, on a different type of US political problem “the Americans can be counted on to do the right thing, after exhausting all other possibilities.” The hard truth is that the US system of medical care payments has never been an effective way to reward high quality primary care; many industrialized countries have had additional incentives for years, and others are implementing such presently. For example, encounter-based fees don’t encourage after hour access, care coordination or comprehensive clinical services. Furthermore researchers have clearly shown that prevention, chronic illness care, interdisciplinary teams, culture and language-appropriate services, community engagement, informed patient decision-making, generalist-specialist coordination are all important elements of a high value, efficient delivery system. But these are very hard to buy through our archaic system of visit based payments.

Many questions must be answered to discern the best way to reward these fundamental changes to primary health care. Delivery system reforms must avoid unsustainable mortgages for “medical mansions” or rapid acquisition of shoddy “medical lean-tos” that will collapse in the shifting policy wind. But the medical home promises to be an important and useful frame work for long overdue investments in primary care, which must become the foundation of a reformed US health care system.

*Adapted from the February 2007 “Joint Principles of the Patient-Centered Medical Home” developed by the AAFP, AAP, ACP, and AOA.

Eugene C. Rich MD FACP
Scholar in Residence
Association of American Medical Colleges
Professor of Medicine, Creighton University School of Medicine
Faculty Associate, Center for Health Policy and Ethics
email: richec@creighton.edu