The Medical Home and Generalist Medicine: Bedrock Foundation or Sub-Prime Mortgage?

Eugene Rich MD, FACP
Immediate Past-President SGIM

In recent months health policy makers and health care payers have been acknowledging the impending collapse of primary medical care and offering hopeful pronouncements regarding the "medical home" as the solution to a multitude of health system woes. 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 medical home "buyers" are skittish, however. Payment analysts for CMS (they are located in Baltimore and perhaps less subject to the Beltway Bubble) 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 trio-pathy need more 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?"

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 personal 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 will value.

And many practicing generalist physicians remain highly skeptical. Angry over the problematic trajectory of fee-for service 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 too 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 PAs and NPs- 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 EMR, the extra staff?"

These reactions are understandable; the recent history of US health policy has included many boondoggles. Managed care, the Relative Value Update Committee, Pay for Performance, Disease management companies, so may of these have been a disappointment, or worse, for generalist physicians. Accordingly they are very reluctant to make major investments in personnel and infrastructure to adapt to some ideal of the medical home without greater clarity about the rules of payment, the number of patients to whom this will apply, the long-term future of this innovation.

But the reality is that simple fee for service has never been a good way to reward high quality generalist care; many industrialized countries have had additional incentives for years, and others are implementing such presently. While encounter-based fees are an age-old method to pay physicians, they are not readily adapted to encourage those who are "accessible, comprehensive, coordinated, continuous, and accountable…" (IOM 1978). It takes but a moment's reflection on the documentation requirements for a level 4 follow-up visit, and the sobering reality of the number of specialized encounters billed this way (often as an adjunct to the procedure or the MRI), to realize that even comprehensiveness is hard to detect and reward. Even more difficult is revising encounter based fees to pay for a sophisticated generalist practice with "…the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." (IOM 1996).

Therefore it is fitting that academic general internists be leaders in the movement to adapt US payment models to encourage the care our researchers have shown to be best. Prevention, chronic illness care, interdisciplinary teams, culture and language-appropriate services, community engagement, informed patient decision-making, generalist-specialist coordination, all are evidence- based in HSR but rarely delivered in the private office. Many questions must be answered to discern the best way to reward these fundamental changes to generalist care. We must take care that society not invest in unsustainable "medical mansions" or rapidly assemble "medical lean-tos" that will collapse in the shifting policy wind. But the medical home can be a useful frame work for reform long overdue for general internal medicine, and for US health care.

INSERT?
What is a Medical Home:*
Each patient has an ongoing relationship with a **personal physician** trained to provide first contact, continuous and comprehensive care
Physician-directed medical practice in which a team of individuals collectively take responsibility for ongoing care of patients
Whole-person orientation of care for all stages of life
Care is coordinated and/or integrated across all elements of the health care system
Quality and safety are hallmarks of the medical home
Patients have **enhanced access** to care through systems such as open scheduling, expanded hours and new options for communication
Payment appropriately recognizes the added value to patients who have a medical home

*Adapted from the February 2007 "Joint Principles of the Patient-Centered Medical Home" developed by the AAFP, AAP, ACP, and AOA; now endorsed by SGIM, among numerous physician organizations.