Comprehensiveness Is Key

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sition that everyone should have access to a medical home.

"Many Americans, even among those with comprehensive health insurance, feel 'medically homeless' and lost in a system that is difficult to navigate when they require care," AAMC President Dr. Darrell Kirch said in a statement. "The medical home model holds great promise for improving Americans' health by ensuring that they have an ongoing relationship with a trusted medical professional."

It's not just national groups buying into the concept, though. At least 41 states are currently preparing or considering pilot projects to implement the medical home model in some form; Medicare is scheduled to launch a demonstration project next year and Wal-Mart has begun to explore the potential of the model.

"We listen to our customers," Dr. John Agwunobi, president of Wal-Mart's professional services division, said at the meeting. "We hear them saying that health care is too costly, too complicated, and too controlled."

Enthusiasm of the attendees aside, there was no apparent consensus on what is needed to make the idea of a medical home into a reality.

Although the groups have all signed onto the joint principles, that endorsement doesn't imply any specific responsibilities. It also doesn't imply that everyone agrees on what defines a medical home. There is a wide variety of measurement tools being developed to gauge and document the success of a medical home, and that is just the first step.

"Measurement is an extremely powerful tool. But it is only that. It is not an end in itself. … It gives us a compass so that we can see where we want to go and whether we are going in the right direction," said Dr. David Meyers of the Agency for Healthcare Research and Quality.

As director of AHRQ's Center for Primary Care, Prevention and Clinical Partnerships, he has helped develop a survey tool for measuring care coordination.

Comprehensiveness is the linchpin to what makes primary care so valuable for both patients and the health care system in general. The principles of a medical home include providing all services each patient may need or, if necessary, making sure the patient has access to care outside the practice. In other words, the physician providing a medical home will be responsible for ensuring that patients get appropriate care, while avoiding the trap of the gatekeeper era in which doctors found themselves in the position of denying care, Dr. Meyers said.

Measurement tools will help those launching on the path of a medical home to show progress, but proving the value of this concept quantitatively will be just one challenge, speakers warned.

Physicians, especially those in small or solo practices, will need to be shown that it is worth their time and trouble to adopt quality improvement measures with only the promise of additional compensation. Patients will have to be educated on what a medical home is, why it benefits them, and how they can get one. And payers will have to be convinced that they are getting more for their money.

"Timing is everything," said Helen Darling, president of the National Business Group on Health. The country is in a recession, and companies are going bankrupt or, at the least, cutting costs, she said. "This is not a good time to talk about spending more money."

She encouraged the group to make sure that adoption of the medical home model is budget neutral.

Many at the meeting seemed undaunted.

Dr. William Jagiello an Iowa family physician, exuded the zeal of a new convert when he spoke about the medical home concept. After 29 years of practicing medicine, he said he found himself frustrated by a system that fell short of expectations, both his and patients'.

"I thought about all the things that I should have done for my patients and did not do. It began to dawn on me that the medical home concept would give me the process and the vehicle through which I could be doing all those things for my patients on a daily basis. And perhaps I could come home a lot more satisfied and less exhausted knowing that I have delivered the best care possible," he commented. ■

A Medical Home's Binding Principles

► **Personal physician.** Each patient has an ongoing relationship with a physician who provides continuous and comprehensive care.

► **Physician directed.** A physician-led team collectively takes responsibility for the ongoing care of patients.

► **Whole-person oriented**. A physician is responsible for providing for all a patient's health care needs or arranging care with other qualified professionals.

► **Coordinated care.** A patient's care is integrated across all elements of the health care system and the community.

► **Quality and safety.** Practices adopt a plan of ongoing self-assessment protocols incorporating accountability, information technology, performance measures, and patient feedback.

► **Enhanced access.** Practices use systems such as open scheduling, expanded hours and new options for communication.

► **Appropriate payment.** Payers recognize the added value from a medical home, such as care management and coordination, quality improvement, and savings on hospital visits.

Source: Patient-Centered Primary Care Collaborative

Medical Home Pilot Gets Go-Ahead From MedPAC

BY ALICIA AULT
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WASHINGTON — The concept of a medical home is a step closer to reality for Medicare patients, after it received strong backing from the Medicare Payment Advisory Commission at its April meeting.

All 17 commissioners present at the meeting voted to urge Congress to instruct the Centers for Medicare and Medicaid Services to develop a large pilot study of medical homes for Medicare beneficiaries. The recommendation will be included in MedPAC's June report to Congress.

Most of the commissioners also voted to adjust the Medicare fee schedule to increase payment for primary care, which MedPAC has deemed as undervalued at previous meetings.

The medical home concept has been advanced by the American College of Physicians, the American Academy of Family Physicians, and the American Academy of Pediatrics. A demonstration project is authorized under the Medicare program, but the commissioners said a larger pilot with clear thresholds could accelerate the evaluation process, and easily be discontinued or expanded.

They compiled a wish list of criteria for a medical home, including the ability to provide primary care, use information technology for clinical decision support, conduct care management, offer 24-hour communication with patients, maintain up-to-date records of patients' advance directives, and operate a formal quality improvement program. Also, beneficiaries should agree to adhere to medical home principles by respecting the idea that someone is in charge of coordinating their care, and communicating with the physician when they seek care elsewhere.

There was some debate over whether patients should be allowed to access other providers without a referral, which is permitted under current fee-for-service Medicare. Most of the commissioners wanted some restrictions, or at least a way to track when patients see specialists, to facilitate assessment of the program's success or failure.

The medical home would not be limited to primary care physicians; specialists likely would be able to fulfill criteria for participation, according to the commission's vision.

The program would cost $50-250 million in the first year, and cost less than $1 billion over the first 5 years, MedPAC staffers estimated. The estimate included monthly fees to medical homes, but not anticipated savings, said MedPAC staffer Christine Boccuti.

Dr. Francis Jay Crosson, a commissioner and senior medical director of Permanente Federation in Oakland, called the proposal a "significant evolution" from what had been presented to the panel in 2007.

Commissioner Jack Ebeler, a health policy consultant in Reston, Va., said the promotion of the medical home approach is a direct way to reform the health care delivery system.

Commissioners also said that the medical home recommendation dovetailed with MedPAC's support of increased pay for primary care services.

Dr. Ronald Castellanos, a commissioner and urologist in private practice in Ft. Myers, Fla., said an adjustment to the fee schedule was "long overdue," and increased pay might lure more residents into primary care and help those currently practicing to stay in the workplace.

The commissioners debated how the CMS could determine which physicians or other health providers, such as nurse practitioners, would receive the update. MedPAC staff presented the increase as budget neutral, which made some panelists uneasy.

Dr. Nicholas Wolter of the Billings (Mont.) Clinic suggested that the increase be made without trying to maintain budget neutrality.

But Dr. Karen Borman, professor of surgery at the University of Mississippi, Jackson, expressed concern that rewarding primary care could hurt other physicians. She voted against the recommendation for increased pay for primary care. ■

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