

The Medical Home

Position Statement

March 2008

Introduction

The medical home is a concept or model of care delivery that includes an ongoing relationship between a provider and patient, around the clock access to medical consultation, respect for the patient/family’s cultural and religious beliefs, and a comprehensive approach to care and coordination of care through providers and community services. Its functions are similar to those of effective primary care proposed several decades ago by the Institute of Medicine (IOM), the World Health Organization (WHO), and others. In fact, the term was originally coined in 1967 by the American Academy of Pediatrics (AAP) but the concept in its current form was formulated by the Academy in a 1992 position paper as an “approach to providing comprehensive primary care.”

The AAP, the American College of Physicians (ACP), and the American Academy of Family Physicians (AAFP) have endorsed the medical home as an approach to improving health care delivery in the United States. In most cases, the provider of primary or principal care is a health care team guided by a generalist. The concept, though, is not specialty or provider specific—it was originally conceived as the cornerstone of care for children with special health care needs (CSHCN) who frequently receive the majority of their care from physicians other than general pediatricians. While each of the three specialty societies has previously adopted their own framework for the medical home they collectively issued a statement of “Joint Principles” in March of 2007.

Much of the evidence supporting the medical home model is extrapolated from the literature evaluating primary care, case management, and other approaches to improving care coordination and prevention. However, the limited evidence available from studies more closely examining the role of the medical home is encouraging. Further studies are needed to better define the core functions of the medical home, their optimal implementation, and how strategies might need to be adjusted for populations with different degrees of acute and chronic illness. Perhaps the greatest challenge will be the additional resources required to adopt medical homes before cost savings (if any) are realized.

The Association of American Medical Colleges (AAMC) has recently called for an expansion of medical education and training in the U.S. to ensure that human resources are available to care for a growing population of aging and chronically ill citizens. However, the Association and its members believe that adequate human resources are only the first step to improving the health of communities; and that patients must be able to access effective care for both prevention and treatment.

Despite the need for better information about optimal form and function, and the attendant challenges to implementation, the AAMC believes that the medical home model holds great promise for improving the health of populations and individuals. The AAMC is committed to the following principles:

- 1. Every person should have access to a medical home—a person who serves as a trusted advisor and provider supported by a coordinated team—with whom they have a continuous relationship. The medical home promotes prevention; provides care for most problems and serves as the point of first-contact for that care; coordinates care with other providers and community resources when necessary; integrates care across the health system; and provides care and health education in a culturally competent manner in the context of family and community.**

Many Americans are currently “medically homeless.” The health care system is difficult for patients to navigate when they need care or advice. The system also financially rewards “patchwork” care provided by physicians and other health professionals instead of encouraging continuity and care coordination. These problems are compounded by a lack of interoperable health information systems which make the most important information available to both patients and providers. The medical home, while not a cure all for the current fragmentation, offers a powerful potential alternative model which is likely to improve patient care satisfaction and outcomes.

The functions of the medical home as described above are similar to those of effective primary care and are consistent with those described by the AAP, AAFP, ACP, and others. While few studies have explicitly evaluated the medical home model, there are decades of research evaluating structural components of primary care which suggest that outcomes are improved for patients and populations when systems that enable the core medical home functions are present. The medical home model places emphasis on patients’ ability to receive effective care rather than how that care is provided. However, for medical homes to operate effectively, they must exist within a system of coordinated medical care which supports the person(s) with whom the patient has a primary relationship.

Ideally, patients will have a continuous relationship with a medical home that provides ongoing stability and continuity of care and a point of first contact when problems or questions arise. While patients will benefit from long-term, trusted relationships with physicians and their practices, patients should be free to change medical homes. In some cases, the medical home may shift between providers for a period of time, particularly when patients have acute exacerbations of chronic illness or when they develop new problems. One example would be ante-, peri-, and postpartum care of pregnant women which often shifts to obstetrical practices. Other patients may require successive, long term medical homes with care being directed by different physicians at different times such as oncologists and geriatricians.

In other cases, a non-physician (such as a nurse) may serve as a trusted advisor and medical home to coordinate services effectively and efficiently. Transitions from one medical home to another must be adequately facilitated through patient and provider efforts as well as enhanced information systems. Moreover, both patients and their medical homes should share accountability and each must be readily identifiable to the other. Most importantly, medical homes must be able to provide comprehensive, patient-centered care.

2. Further research is necessary to better understand how to measure the core functions of the medical home and to develop an evidence base for how the model is best implemented.

At the present time, there is insufficient evidence regarding how the medical home is most effectively implemented or how its performance is best measured. Current research has often relied on extrapolation from studies not originally designed to test the medical home model. While there is evidence to suggest that many of the shortcomings of the current system may be addressed by adoption of the medical home model, further research should enhance measurements of the functions of the medical home and improve understanding of how these functions can be incorporated into the delivery of health care while improving the health of patients and communities.

Workforce implications will also need to be examined; improved coordination will require increased time and effort on the part of principal physicians and their teams, thereby decreasing the availability of physicians. However, many medical home functions may decrease the time and effort required of other

physicians. In addition, some of the functions can be delivered by non-physicians, including NPs and PAs, which could potentially decrease demand for physicians. These workforce considerations must be made with an understanding of the health care needs of different segments of the population where the coordinating provider's expertise and training represents the best match with the patient's relative health or illness.

3. Payment for the medical home model should appropriately recognize and reward health care providers for their contributions to prevention, patient care, and care coordination.

The current reimbursement system typically requires face-to-face physician encounters providing little incentive for practice innovation. Legislative and regulatory solutions for problems with Medicare payments have been discussed over several years in a variety of settings. The role of primary care and adequate payment for primary care services has been a key discussion point in the debates and continues to be so in 2007. Although the specialty groups most identified with the medical home initially advocated for recognition of the importance of primary care, the concept has now gained wide-spread recognition and increasing support among policy makers and organizations responsible for health policy, such as MedPAC.

In light of this, and the important role of all clinical specialties and providers, AAMC supports adequate payment for the fundamental cornerstones of the medical home model—patient centered care, alternative delivery/care coordination methods (such as telemedicine services or electronic “e-mail” and “e-visit” communications systems), and payment for a comprehensive set of services that includes a “global” approach to care, no matter what type of specialist is providing care (e.g., a model that includes specialists and non-physician care team providers).

Under such an approach, the appropriate care for the patient, at the appropriate time, could be delivered and separated from the specialty role of the physician and others providing care. This process will require an up-front infusion of funds, as well as an algorithm for ensuring an appropriate balance of reimbursement among providers, for the transition to a medical home model.

4. Health care providers should be trained to understand and enact the medical home model as part of a team.

The need for enhanced training around the medical home model is not limited to physicians in one specialty or one category of health professionals even though, for the vast majority of patients, the medical home will be directed by a generalist physician who is part of a larger team of professionals. Patients with particularly complex or severe conditions (e.g., advanced HIV disease, uncontrolled diabetes, and organ transplants) may require a specialist-led team to serve as the principal provider of care while coordinating other services as appropriate. However, many specialists may not be adequately prepared for providing out-of-scope services even in large, multi-specialty group practices or academic medical centers. The care of appropriate patients by specialist-led teams will require close coordination among team members and providers outside of the medical home. Conversely, generalists may not be well equipped to coordinate and provide the principal care for patients with special health care needs.

Educating and training physicians (and other health professionals) to effectively fulfill the functions of a medical home will pose challenges for medical schools and teaching hospitals. However, all physicians will have a role in care coordination directly or indirectly and will either refer patients or have patients

referred to them. As a result, it is important that health care providers be trained to understand effective coordination and improve their communication with other team members across the professional spectrum.

While non-physician providers (such as nurse practitioners and physician assistants) could provide a wide range of services in the medical home model, their numbers are currently insufficient to provide all appropriate preventive care and coordination of services. Many services may be provided by a well-trained medical assistant, LVN/LPN, or RN working in conjunction with other health professionals with more advanced training. Health education and training should promote the delivery of health care by professionally diverse teams; this will require innovative models of interdisciplinary education and greater flexibility than current arrangements for financing graduate medical education allow.

5. AAMC is committed to working with its member institutions to better understand how the medical home model can best be adopted in academic and community settings.

With proper research, capital, and operating financial support, medical schools and teaching hospitals should provide research on how best to achieve the goal of providing care in a medical home whether it occurs in academic settings or in the larger community. Patients in academic centers are more likely to have complex and chronic conditions, making coordination among providers difficult, even within an integrated institution. A lack of patient resources also impedes participation in self-care and management, as can language barriers, both of which are common in patients seen in teaching institutions. All of these will be difficult to overcome; however, these patients may be the most likely to benefit from improved access to and coordination of care. The AAMC is committed to working with the broader health care community (including the authors of the Joint Principles) to promote further understanding of the medical home model.

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