

## **AMA Position Statement on the Medical Home**

November 2015

### **1. Introduction**

The AMA recognises the potential for the medical home model of primary care to support and reward quality general practice, and especially to enable well-coordinated multi-disciplinary care for patients with chronic and complex diseases. Adoption of the model in the US and other countries has resulted in improved quality measures, performance and service use, with a highly significant reduction in avoidable hospital admissions, emergency department use and overall care costs.<sup>1</sup>

The medical home refers to a model of primary care that is patient-centred, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.<sup>2</sup> This has become a model for how primary care can be organised and delivered in a health system. It encourages providers and care teams to meet patients' needs where they are (in their medical home), from the simplest to the most complex conditions. In the Australian context, the vast majority of patients already consider general practice to be their medical home. Ninety three percent of patients return to the same practice and 66% of patients to the same GP.<sup>3</sup> General practice is therefore the natural location for a medical home.

The medical home should build on the strengths of the existing Australian general practice based primary care system, which has demonstrated benefits. Data from the Organisation for Economic Co-operation and Development (OECD) demonstrating that it is one of the most efficient and highly performing health systems in the world.

A key concern for the AMA is patient benefit. Unless there is patient benefit there is no point to this reform. There can only be patient benefit if the Government provides extra funding, which will allow GPs to provide better care for patients through non face-to-face activity, better coordination and better targeting.

This position statement outlines key principles and requirements for the medical home that the AMA believes would provide benefits and improve patient care. These principles are consistent with the interests of General Practice in Australia and broader AMA policy considerations.

### **2. AMA Model for Medical Home**

The following are key principles and requirements for medical home that the AMA believes would provide benefits and improve patient care, consistent with the interests of General Practice in Australia:

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<sup>1</sup> Jackson, C. L. (2012) Australian general practice: primed for the "patient-centred medical home"? *Med. J. Aust.* 2012, 197(7): 365-366

<sup>2</sup> Patient-Centred Primary Care Collaboratives. Defining the medical home: A patient-centred philosophy that drives primary care excellence. <https://www.pcpcc.org/about/medical-home>

<sup>3</sup> The Menzies-Nous Australian Health Survey 2012

## 2.1 Key principles

- *Long-term relationship*

The medical home should encourage the development of a long-term stable relationship between the patient and the GP and the practice. The patient must see tangible benefits from the decision to voluntarily register with the GP and the practice. This may involve enhanced access to care or advice, cheaper medicines, preventive medicine, and coordinated and integrated care.

To encourage stability of the long-term relationship, there should not be high up-front payments to the GP for enrolling the patient and there must be reasonable notice by the patient of their intention to choose another medical home.

- *Integrated primary health care team*

The medical home enhances the capacity of general practice to coordinate the primary health care team, which includes the GP, specialists, practice nurses and a range of allied health providers. An integrated health care team spearheaded by the GP is best placed to improve health care provision for patients and to avoid the fragmentation of care, which is emerging as a feature of our system. GPs are the most appropriately trained health professionals to provide holistic care and have established themselves in a relationship of trust and integrity with patients.

- *Coordinated and integrated care*

Patients with chronic and complex care needs need access to a broad range of allied health services. The GP is best placed to understand the patient need for these services and the medical home allows the Care Team to ensure care is appropriately coordinated and provided in accordance with the agreed care plan.

- *Preventive health focus*

Patients already look to their GP for advice on preventive care particularly those patients who are already regular visitors to their GP for related care. The creation of the medical home with voluntary registration would provide a defined group of patients which would assist in the coordination of and provision of preventive health services. The GP could assume a greater role than presently exists within broader national priorities and Government programs and incentives.

- *Registration is voluntary and reversible and does not lead to Government control*

Voluntary registration is more in keeping with the AMA approach to health system design and would be more acceptable to patients who may be alarmed by any suggestion of compulsion. Patients should never surrender their universal access to rebates under the MBS and this should never be required as a condition of participation.

Patients should be free to terminate registration with one practitioner/practice with two weeks notice in order to register with another practitioner/practice or remain unregistered.

- *Fee-for-service is retained*

Fee for service has ensured adequate access for patients and has maintained clinical independence for doctors which ensures doctors provide the best care and advocacy for patients. Agreement to participate in a system of registration should reinforce the key role of fee-for-service.

- *Data driven improvement*

The medical home offers an opportunity to collect data, which will help drive improvements to patient care. Data collection systems need to be well-designed, focusing on the collection and analysis of relevant de-identified clinical information. This data can provide practices with the opportunity to identify areas for improvement and monitor progress in these identified areas.

Practices should have a high degree of flexibility in the clinical indicators and measures they use and these should be relevant to the context in which the practice operates and the many factors that can impact on patient outcomes. Funding should be provided to support the collection and analysis of data and it must not be used in such a way that practices can be penalised. The AMA position statement on [Clinical Indicators](#) provides further guidance on this.

- *A minimum of bureaucracy*

In Australia, we have been fortunate to avoid the worst excesses of the US and UK health systems which require very significant administrative overheads within the medical practice to match the bureaucratic demands of government. We must be careful to retain this benefit in the Australian health system and ensure that performance reporting arrangements are designed with full involvement of the medical profession and can be distilled from clinical care information.

## 2.2 Requirements

- *Increased investment in General Practice*

The Australian medical home should only be introduced if there are good patient benefits and this will only be achieved if accompanied by increased Government investment in general practice and primary healthcare. Rural, remote and disadvantaged communities and conditions that have poorer health outcomes must also share in additional resourcing. To curb the rate and exacerbation of chronic disease in this country and the associated long-term costs to the health system associated with it, the Government must provide additional resources to support General Practice in delivering preventive, comprehensive, coordinated and integrated health care. Supporting general practice in this way will reduce patient risk factors, reduce wastage through duplication of services, and prevent avoidable hospital admissions.

- *Implementation*

An appropriate role for primary health care organisations (PHCOs) would be to assist practices in implementing medical home principles and systems, and

PHCOs should be appropriately funded to provide these services to general practices.

- *Targeting Chronic Disease*

The medical home should focus on supporting patients with higher chronic and complex care needs, including those requiring palliative care.

- *Payment through PIP/SIP*

The AMA does not support the creation of an up-front patient registration fee because of the incentives this will provide to treat it as a commercial benefit.

The AMA recommends a PIP/SIP style funding model for the medical home. This type of model would not only support general practices to put in place appropriate infrastructure and processes but would also recognise the role of the practitioner directly providing the patient care. Funding via the PIP must also support general practices with managing the change to any model of care which formalises the medical home.

PIP/SIP style funding is well established and understood; and is similar to other programs such as the Department of Veterans' Affairs Coordinated Veterans Care model and the PIP Indigenous Incentive which acknowledge the distinctive roles of the practice and the GP in the provision of longitudinal, comprehensive and coordinated care. While only accredited practices, or those committed to accreditation are eligible for PIP more flexible arrangements will be required for the medical home. Special arrangements will need to be developed to ensure that smaller practices, which tend not be accredited, are not excluded from being a patient's medical home.

Where a different funding model is proposed, it should be at least as administratively efficient and maximise the funding available to support practices and GPs in relation to the establishment of appropriate infrastructure, processes and delivery of care.

- *No capitation*

The AMA has longstanding policies opposing capitation and these continue to operate.

While the AMA acknowledges that the medical home concept has the potential to provide a platform for blended funding models that reward quality general practice, there is concern regarding the potential use of capitation as a strategy for health care quality improvement and cost containment, as proposed by some supporters of the model. Several types of undesired effects of capitation have been postulated, including under use of effective services, avoidance of high-risk patients, and an increase in the number of reimbursements, which increases health spending.<sup>4</sup>

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<sup>4</sup> Agency for Healthcare Research and Quality (2012) Opt cit.

### 3. Background

#### 3.1 The concept

The medical home concept has as its cornerstone the chronic care model. Interventions based on the chronic care model and focused on single conditions such as diabetes, asthma, chronic obstructive pulmonary disease, or depression, have been shown to improve patient outcomes and/or quality of care. The medical home builds on this model and is intended to address the full range of patient-focused health care needs.

The medical home, has gained traction in the United States and other countries such as Canada, France, the UK, Germany, the Netherlands, Sweden and New Zealand. It is a model of care that strengthens the role of general practitioners in the health system and delivers better outcomes for patients by encouraging integrated, co-ordinated, comprehensive, and longitudinal care.

#### 3.2 The Principles

The medical home initiative, which describes a primary care model aimed at better meeting the needs of contemporary communities, was launched in 2007 by a number of colleges and academies in the US.<sup>5</sup> The key elements of the model are: patient-centred, comprehensive, team-based, coordinated, and accessible care, plus quality and safety.<sup>6</sup>

The model has since evolved, and more recently, Bodenheimer et al (2014)<sup>7</sup> identified 10 building blocks that can help practices in their journey toward becoming high-performing medical homes. These include:

1. Engaged leadership, creating a practice-wide vision with concrete goals and objectives;
2. Data driven improvement using computer-based technology;
3. Empanelment, linking patient to a care team and a primary care clinician;
4. Team-based care;
5. The patient-team partnership that recognises the expertise that patients bring to the medical encounter, as well as the evidence base and medical judgement of the clinician and team;
6. Population management - practices that stratify the needs of their patients and design team roles to match those needs;
7. Continuity of care which links each patient to a clinician and team;
8. Prompt access to care and allowing patients to decide which takes priority;
9. Comprehensiveness and care coordination – the capacity of a practice to provide most of what patients need and to arrange for services that primary care is unable to provide; and
10. Template for the future – a daily schedule that does not rely on the 15-minute in-

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<sup>5</sup> Jackson, C.L. (2012) Australian general practice: primed for the “patient-centred medical home”? *Med. J. Aust.* 2012, 197(7): 365-366 <https://www.mja.com.au/journal/2012/197/7/australian-general-practice-primed-patient-centred-medical-home>

<sup>6</sup> Agency for Healthcare Research and Quality. Defining the PCMH. <http://www.pcmh.ahrq.gov/page/defining-pcmh>

<sup>7</sup> Bodenheimer et al (2014) The 10 Building blocks of high-performing primary care. *Annals Fam. Med.* Vol. 12, No 2.

person clinician visit but offers patients a variety of e-visit, telephone encounters, group appointments, and visits with other team members.

### 3.3 Effectiveness

In a study published by the New York based Commonwealth Fund, it was suggested that the medical home may have a role in reducing disparities in access and levels of care.<sup>8</sup> In this study, the definition of the “medical home” referred to a practice that offers patients a regular source of care, enhanced access to physicians, and timely, well-organised care (based on a patient experience of care survey). The study revealed that patients who reported having access to their definition of a medical home received a higher level of preventative and chronic illness care regardless of insurance status, race or gender versus patients cared for in practices that lacked those characteristics.<sup>9</sup>

A report based on an analysis of 31 studies of the medical home model released by the US Agency for Healthcare Research and Quality,<sup>10</sup> concluded that, while the model was promising in relation to improving the experiences of patients and care processes, further evidence was required to make a firm determination regarding its effect on clinical and economic outcomes.

## **4. Medical Home in the Australian context – key AMA issues**

The concept of the medical home in Australia to some extent already exists in the form of the ‘usual GP’ the cornerstone of which is an established and trusted relationship between doctor and patient. The fee-for-service financing arrangements in Australia support patient choice regarding their health care service providers and allow funding to follow the patient. The majority of Australians have a usual GP or usual GP practice suggesting they already have a medical home. Evidence suggests that patients with a ‘usual GP’ or medical home have better health outcomes.

However, under Medicare, medical services are primarily remunerated on a face-to-face basis, with shorter consultations better remunerated than longer consultations. There needs to be greater recognition and remuneration of the non face-to-face work involved in providing comprehensive care. This work includes, collecting and analysing patient data to drive quality improvement, conferencing with other members of the health care team, patient follow-up and recall, patient education and care coordination. In this regard, formalising the relationship between the patient and doctor (as proposed by the medical home model) will provide a basis on which funding to support comprehensive and longitudinal care can be directed to the responsible medical service provider.

The medical home in Australia should embrace rather than compromise patient choice of practitioner or medical practice. The AMA has never supported mandatory registration

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<sup>8</sup> Beal, C. et al (2007) “Closing the divide: How medical homes promote equity in health care” results from the Commonwealth Fund 2006 Health care Quality Survey, The Commonwealth Fund, 2007

<sup>9</sup> Beal, C. et al (2007) “Closing the divide: How medical homes promote equity in health care” results from the Commonwealth Fund 2006 Health care Quality Survey, The Commonwealth Fund, 2007

<sup>10</sup> US Agency for Healthcare Research and Quality (2012) The patient-centred medical home: Closing the gap – revisiting the state of the science <http://www.ahrq.gov/clinic/tp/gappcmhpt.htm>

because it denies patient choice and also because mandatory systems increase the control of Government over the provision of medical services, which is by definition undesirable.

It is vital that patients retain their freedom to choose their medical practitioner and that patient universal Medicare rebate entitlements are not curtailed. It is also vital that payment/reimbursement systems do not provide incentives to GPs to restrict the provision of care or to select against high demand patients. Fee-for-service must remain the predominant model.