A House Is Not A Home: Keeping Patients At The Center Of Practice Redesign

The patient-centered medical home could well be a transformative innovation—for some practices now, but for many others only in the long run.

by Robert A. Berenson, Terry Hammons, David N. Gans, Stephen Zuckerman, Katie Merrell, William S. Underwood, and Aimee F. Williams

ABSTRACT: The "patient-centered medical home" has been promoted as an enhanced model of primary care. Based on a literature review and interviews with practicing physicians, we find that medical home advocates and physicians have somewhat different, although not necessarily inconsistent, expectations of what the medical home should accomplish—from greater responsiveness to the needs of all patients to increased focus on care management for patients with chronic conditions. As the medical home concept is further developed, it will be important to not overemphasize redesign of practices at the expense of patient-centered care, which is the hallmark of excellent primary care. [*Health Affairs* 27, no. 5 (2008): 1219–1230; 10.1377/hlthaff.27.5.1219]

THE PATIENT-CENTERED MEDICAL HOME (PCMH) is the newest idea being promoted as a transformative health system innovation. Proponents believe that it will improve the quality of and patients' experiences with care and alter the trajectory of inflationary health care spending.[1] The PCMH has been proposed by four primary care physician specialty societies; has been endorsed by a range of purchaser, labor, and consumer organizations, including IBM, Merck and Company, the ERISA Industry Committee, and AARP; and is being tested in demonstrations by major public and private health plans, including Medicare, various Blue Cross and Blue Shield plans, UnitedHealthcare, and Aetna.[2] The medical

Robert Berenson (rberenson@urban.org) is a senior fellow at the Urban Institute in Washington, D.C. Terry Hammons is a senior fellow at the Medical Group Management Association and the MGMA Center for Research in Englewood, Colorado. David Gans is vice president of practice management resources at the MGMA. Stephen Zuckerman is a principal research associate at the Urban Institute's Health Policy Center. Katie Merrell is a senior research scientist at Social and Scientific Systems in Silver Spring, Maryland. William Underwood is a senior associate at the American College of Physicians, Center for Practice Innovation, in Washington, D.C. Aimee Williams is a research assistant at the Urban Institute's Health Policy Center.

DOI 10.1377/hlthaff.27.5.1219

home has even been promoted as part of health system reform by the presidential candidates in 2008.[3]

A medical home, in broad terms, is a physician-directed practice that provides care that is "accessible, continuous, comprehensive and coordinated and delivered in the context of family and community."[4] The current interest in the medical home has derived from growing recognition that even patients with insurance coverage might not have an established source of access to basic primary care services and that care fragmentation affects the quality and cost of care.[5]

There is hope that primary care physician (PCP) practices, serving as medical homes, can bring some order to this chaos, providing a source of confidence, advocacy, and coordination for patients as they encounter the disconnected parts and often daunting complexity of the health care system. However, various PCMH advocates have different, although not inconsistent, expectations and emphases. For some, the concept relates mostly to the "patient-centered" component; for others, the most salient characteristics are found in improving the "systemness" of care, aided by new health information technology (IT) and organizational structures; while still others emphasize chronic care management.

Although the primary care societies and other members of the coalition supporting the medical home have been careful to call for demonstrations to learn more about it, the current policy buzz may be stimulating unrealistic expectations about the medical home's immediate potential. It would not be the first time that a good health policy idea was judged a failure because of premature promotion. We argue that there is a need to achieve broader consensus on what medical homes reasonably can be expected to accomplish, and how they can best be developed in different practice environments and supported with altered payment policies.

This study is part of a larger research effort that eventually will identify the incremental costs associated with adopting the PCMH, as defined in standards promulgated by the National Committee for Quality Assurance (NCQA) in its Practice Recognition program. In beginning this work, we conducted site visits to a variety of practices to see whether and how they were implementing elements of the PCMH Standards and heard differences of opinion about what the PCMH should emphasize and be rewarded for. Given these divergent views, we conducted a literature review of the concept and further discussed the topic with numerous physicians and policy experts interested in promoting an increased primary care role in health care delivery. In this paper, we identify the main health system problems that the medical home has been promoted to address; review the various developments that have resulted in current concepts of the PCMH, emphasizing the areas of divergent opinion; and discuss the main challenges that the medical home concept currently faces.

Problems That Medical Homes Might Address

■ **Deficiencies in patient-centered care.** The Institute of Medicine's (IOM's) *Crossing the Quality Chasm* report identified patient-centered care as one of six overlapping domains of clinical care quality, along with safety, effectiveness, timeliness, efficiency, and equity.[6] The Picker Institute has delineated eight dimensions of

quality significantly.[13]

In contrast, the Chronic Care Model (CCM), developed by Edward Wagner and colleagues at the MacColl Institute in Seattle, has had some success in improving care and reducing costs for patients with chronic conditions.[14] The CCM is a primary care–based approach that conceptualizes care as being provided by multidisciplinary practice-based teams in productive interactions with informed, motivated patients. The CCM calls for health care organizations to implement delivery system redesign, patient self-management support, systematic decision support, clinical information systems, and links to available community resources.[15]

The CCM has proved effective in certain practice environments, usually in a research or demonstration context, but

Evolution Of The Patient-Centered Medical Home Concept

In 2007 the American Academy of Family Practice (AAFP), the American College of Physicians (ACP), the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA) announced joint principles of a "patient-centered medical home," consolidating perspectives that the societies had developed separately. Here we trace the evolution of the PCMH concept and how it converged into its current definitions.

■

Carolina Access (in North Carolina Medicaid) enrolled PCPs to serve as patients' physician care managers—and as gatekeepers to more specialized services—and in return, Medicaid agreed to pay participating physicians a modest monthly fee in addition to the usual fee for service, to assure that physician practices would be available for phone access around the clock as a way to decrease unnecessary emergency room (ER) visits.[28] This approach is now being broadened in Community Care of North Carolina for patients with chronic conditions as a complement

attributes have been given too little attention in the recognition standards.

■ **Primary care versus the CCM.** In summary, patient-centered primary care and the CCM were developed to focus on different challenges. The former evolved as a model for how practices should respond to all patients in a practice and emphasized attributes that excellent traditional practices have long exemplified, despite nonsupportive reimbursement. In contrast, the CCM was originally developed as a multidisciplinary, team-based approach to support specific patients with chronic conditions and emphasized redesign of office practice to include care techniques promoting patients' self-management skills and providers' population management.

Partial convergence of the different evolutionary streams has resulted in a potential tension among objectives and suggests the need to clarify exactly what the PCMH should and can be. The different emphases also invite the question of whether practices that do a superb job of providing patient-centered primary care should be eligible for additional payments as a medical home or whether such supplements should be reserved only for practices being redesigned to carry out the various components of the CCM.

A related issue is whether current PPC-PCHM standards give too much weight to technology-dependent standards compared to access, communication, and care coordination, and whether they overspecify what practices must accomplish, thereby imposing an inordinate reporting burden. As one physician interviewee observed, the NCQA recognition tool should be called "data-centered" rather than "patient-centered," because of his perception of a misplaced emphasis on documentation requirements.

The supporting physician organizations believe that the NCQA's PPC-PCMH recognition tool can evolve over time, based on the results of demonstrations and ongoing practice feedback. A concern is that others will evaluate physician performance against the current standards and not wait for demonstration results to assess success of this heavily promoted innovation.

Challenges To PCMH Adoption

Accepting for this discussion the view of the PCMH incorporated into the NCQA recognition standards, there are challenges to accomplishing the objectives of broad adoption of the medical home in general and this model in particular.

■ **Practice culture and structure.** In their seminal article providing the rationale for the CCM, Wagner and colleagues identified barriers to proper management of chronic care in traditional practices. They wrote, "Amidst the press of acutely ill patients, it is difficult for even the most motivated and elegantly trained providers to assure that patients receive the systematic assessments, preventive interventions, education, psychosocial support, and follow-up that they need."[32]

Based on our interviews with physician leaders and practice managers, we think that there is growing understanding and interest in chronic care management but a persistent presence of the "tyranny of the urgent" in everyday practice.

care patients. The Centers for Medicare and Medicaid Services (CMS) has provided an expansive definition of eligibility, however, such that more than 80 percent of beneficiaries qualify for inclusion in the upcoming demonstrations. Nevertheless, many typical small practices would not have enough patients to justify practice redesign for the small number of chronic care patients they serve.

■ **Management challenges.** Implementation and operation of a full-featured medical home requires much management capability as well as physician leadership.[38] It requires developing processes and systems (including IT) to support high levels of access for and communication with patients, coordination of patients' care within and outside the practice, capturing and using data for care of patients and populations and evaluation of performance, and support for evidence-based decision making. These are challenges for any physician practice, not just smaller ones, as demonstrated by the lack of adoption by even large groups of important health care processes thought to produce better-quality care.[39]

■ **Unfettered expectations.** It seems that every policy advocate has a favorite—and worthy—objective for the medical home beyond patient-centered care and adoption of EMRs and the CCM. Some call for a commitment to formal shared patient-physician decision making. Others see the medical home as better able to identify particular clinical areas that deserve greater attention, such as unexpressed depression or alcohol dependence. Still others emphasize the need for greater cultural competence and attention to varying degrees of health literacy. Appropriate emphases will surely vary by location and patient population served.

As noted earlier, we learned on site visits that the result of well-intentioned medical home expectations could well be that beleaguered PCPs will decline an invitation to receive additional PCMH payments for what they view as unrealistic expectations and unwanted obligations. Indeed, some physicians who think that they do an excellent job on the primary care basics of patient-centered care are skeptical of some of what others think they should be doing.

For example, some physicians question the use of disease registries to seek out patients who have missed routine follow-up appointments when the practice offers flexible scheduling and provides patient education. They point out that patients have their own responsibilities to jointly sustain a satisfactory physician-patient relationship, implicitly questioning the rationale for the NCQA's emphasis on population health. One of the doctors we interviewed, who had experimented with proactive population management, claimed that only a small percentage of diabetic patients contacted regarding needed tests actually initiated care as a result. It is possible that a more dedicated entity located in the community, perhaps at the health department or community hospital, would do a better job with population health than a small physician's practice could.

Further, a number of respondents view traditional, face-to-face office visits as the core of their professional activities and could not imagine relying on alternative approaches emphasizing greatly expanded use of e-mail and phone communi-

cation. Similarly, some physicians could not imagine delegating medication renewals to nonphysicians, as called for in the PPC-PCMH standards, because of their concerns about medication errors. Some were also skeptical of e-mail, believing that phone conversations generally were a more reliable method of resolving patients' questions and concerns—while limiting their own time requirements.

It must be pointed out that other interviewed physicians were eager to reengineer their practices to carry out the intent of expansive PCMH architects. Some have already begun such reengineering, even before extra payments were being provided to support the expanded vision of care, and they would welcome additional financial support to do even more.

Concluding Remarks

■ **Physicians' reluctance and fee-for-service.** Some interviewed physicians, acknowledging that they were feeling overwhelmed, underappreciated, and underpaid, told us not to "help" them, even with additional payment, by expecting their practices to carry out activities they were not capable of or interested in providing. We speculate that some of the reluctance to embrace the current NCQA standards might be conditioned by a fee-for-service payment system built around face-to-face visits. Fee-for-service may also be responsible for supporting the current orientation to providing acute care services, rather than managing chronic conditions, and the current physician-centric view of practice held by many physicians.

With additional compensation, physicians might adopt very different attitudes about what they would be willing and eager to do to improve the care their practices provide. That said, many practices, including some that appear to do a conscientious job of providing patient-centered primary care, will feel threatened by a medical home model that immediately disrupts the basic orientation of their practices and, implicitly, threatens their professional self-esteem.

■ **Dangers of redefining primary care.** The PCMH could well be a transformative innovation—for some practices now, but for many others only in the long run. Our concern is that in moving so decisively to emphasize new responsibilities that implicitly assume reliance on various EMR functions and adoption of the challenging elements of the CCM, current PCMH recognition standards may leave behind crucial aspects of patient-centered care and the physicians who provide it.

Writing presciently in 2002, before the recent flurry of PCMH activity, Gordon Moore and Jonathan Showstack said, "Primary care could also expand beyond its more restricted role as provider of medical care and become engaged in the analysis of population needs and provision of preventive interventions for risk groups, communities and other specific populations. The danger, of course, is that primary care's new role will be even more expansive and varied than today's already diverse activities. A redefinition of primary care must be cognizant of this risk, focus on optimizing primary care's strengths, and avoid assuming too many peripheral responsibilities in its formulation."[40]

Work on this paper was supported by the Commonwealth Fund and the American College of Physicians. The authors thank Melinda Abrams, Michael Barr, and Shari Erickson for their insights and assistance, and the physicians and staff at the site-visit practices for their active participation.

NOTES

1. American Academy of Family Physicians, "Joint Principles of a Patient-Centered Medical Home Released by Organizations Representing More than 300,000 Physicians," 5 March 2007, http://www.aafp.org/online/en/home/media/releases/2007/20070305pressrelease0.html (accessed 20 June 2008).
2. A complete list of endorsers is available from the Patient-Centered Primary Care Collaborative, "Collaborative Members," 2007, http://www.pcpcc.net/content/collaborative-members (accessed 30 April 2008).
3. "Remarks by John McCain on Day One of the 'Call to Action' Tour," 28 April 2008, http://www.johnmccain.com/Informing/News/Speeches/5e30a29e-6e89-4cb2-9035-aacd094fbd86.htm (accessed 9 July 2008); and "Barack Obama's Plan for a Healthy America," http://www.barackobama.com/pdf/HealthPlanFull.pdf (accessed 9 July 2008).
4. AAFP, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, "Joint Principles of the Patient-Centered Medical Home," March 2007, http://www.medicalhomeinfo.org/Joint%20Statement.pdf (accessed 10 April 2008).
5. K. Sack, "In Massachusetts, Universal Coverage Strains Care," *New York Times*, 5 April 2008.
6. Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the Twenty-first Century* (Washington: National Academies Press, 2001), 39–56.

Change," New England Journal of Medicine 356, no. 12 (2007): 1201–1203.

21. A.H. Goroll et al., "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care," Journal of General Internal Medicine 22, no. 3 (2007): 410–415.
22. C. Sia et al., "History of the Medical Home Concept," Pediatrics 113, no. 5 Supp. (2004): 1473–1478; and P.W. Newacheck, J.P. Rising, and S.E. Kim, "Children at Risk for Special Health Care Needs," Pediatrics 118, no. 1 (2006): 334–342.
23. J.S. Palfrey et al., "The Pediatric Alliance for Coordinated Care: Evaluation of a Medical Home Model," Pediatrics 113, no. 5 Supp. (2004): 1507–1516; and AAP, "Health Services for Children With and Without Special Needs: The Medical Home Concept," Periodic Survey no. 44, http://www.aap.org/research/periodicsurvey/ps44aexs.htm (accessed 17 June 2008).
24. "Declaration of Alma-Ata," WHO Chronicle 32, no. 11 (1978): 428–430.
25. B. Starfield and L. Shi, "The Medical Home, Access to Care, and Insurance: A Review of Evidence," Pediatrics 113, no. 5 Supp. (2004): 1493–1498; and M.S. Donaldson et al., eds., Primary Care: America's Health in a New Era (Washington: National Academies Press, 1996).
26. B. Starfield, L. Shi, and J. Macinko, "Contribution of Primary Care to Health Systems and Health," Milbank Quarterly 83, no. 3 (2005): 457–502.
27. S. Trude, "So Much to Do, So Little Time: Physician Capacity Constraints, 1997–2001," Results from the Community Tracking Survey no. 8, May 2003, http://www.hschange.com/CONTENT/556/556.pdf (accessed 30 April 2008).
28. S. Wilhide and T. Henderson, "Community Care of North Carolina: A Provider-Led Strategy for Delivering Cost-Effective Primary Care for Medicaid Beneficiaries," June 2006, http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/state/medicaid/ncexecsumm.Par.0001.File.tmp/ncexecsummary.pdf (accessed 15 April 2008).
29. K. Davis, S.C. Schoenbaum, and A.M. Audet, "A 2020 Vision of Patient-Centered Primary Care," Journal of General Internal Medicine 20, no. 10 (2005): 953–957.
30. S.H. Scholle, A.S. O'Malley, and P. Torda, "Designing Options for CMS's Medical Home Demonstration: Defining Medical Homes," Second Draft (Washington: Mathematica Policy Research, 4 December 2007); Deloitte Center for Health Solutions, "The Medical Home: Disruptive Innovation for a New Primary Care Model," 2008, http://www.deloitte.com/dtt/cda/doc/content/us_chs_MedicalHome_w.pdf (accessed 15 April 2008); and E.E. Stewart et al., "Evaluators' Report on the National Demonstration Project (NDP) to the Board of Directors of TransforMED," 5 February 2008, http://www.transformed.com/evaluatorsReports/report5.cfm (accessed 17 June 2008).
31. Edward Wagner, MacColl Institute for Healthcare Innovation, personal communication, 21 April 2008.
32. Wagner et al., "Organizing Care for Patients with Chronic Illness."
33. Wagner et al., "Improving Chronic Illness Care."
34. A. Liebhaber and J.M. Grossman, "Physicians Moving to Mid-Sized, Single-Specialty Practices," Results from the Community Tracking Survey no. 18, August 2007, http://www.hschange.org/CONTENT/941/941.pdf (accessed 30 April 2008).
35. L.G. Moore and J.H. Wasson, "The Ideal Medical Practice Model: Improving Efficiency, Quality, and the Doctor-Patient Relationship," Family Practice Management 14, no. 8 (2007): 20–24.
36. C.M. Boyd et al., "A Pilot Test of the Effect of Guided Care on the Quality of Primary Care Experiences for Multimorbid Older Adults," Journal of General Internal Medicine 23, no. 5 (2008): 536–542.
37. M.L. Sylvia et al., "Guided Care: Cost and Utilization Outcomes in a Pilot Study," Disease Management 11, no. 1 (2008): 29–36.
38. R.J. Baron and C.K. Cassel, "Twenty-first-Century Primary Care: New Physician Roles Need New Payment Models," Journal of the American Medical Association 299, no. 13 (2008): 1595–1597.
39. L. Casalino et al., "External Incentives, Information Technology, and Organized Processes to Improve Health Care Quality for Patients with Chronic Diseases," Journal of the American Medical Association