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# The Patient-Centered Medical Home

## Will It Stand the Test of Health Reform?

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**T**HE FUNDAMENTAL CHALLENGE FOR HEALTH CARE REFORM in the United States is to expand access to all US residents, while rapidly reengineering the delivery system to provide consistently high-quality care at lower overall cost. Current reform discussions recognize that success will require a shift in emphasis from fragmentation to coordination and from highly specialized care to primary care and prevention.

One prominent model of delivery system reform is the patient-centered medical home (PCMH). Crafted by the primary care professional organizations in 2007, the model has been endorsed by a broad coalition of health care stakeholders, including all of the major national health plans, most of the Fortune 500 companies, consumer organizations and labor unions, the American Medical Association, and a total of 17 specialty societies.<sup>1</sup> Currently, 22 multistakeholder demonstration pilot projects are under way in 14 states, and the Centers for Medicare & Medicaid Services will conduct Medicare demonstration pilot projects in 400 practices in 8 regional sites in 2009.<sup>2,3</sup> Twenty bills promoting the PCMH concept have been introduced in 10 states.<sup>4</sup>

### The 4 Cornerstones of the PCMH Model

The PCMH model is founded on 4 cornerstones: primary care, patient-centered care, new-model practice, and payment reform. Each is deemed essential for the success of the model, and each poses unique challenges.

**Primary Care.** The importance of primary care is based on decades of research demonstrating its role in producing improved outcomes at lower costs.<sup>5</sup> Primary care is defined in the PCMH model as comprehensive, first-contact, acute, chronic, and preventive care across the life span, delivered by a team of individuals led by the patient's personal physician. It also encompasses the essential primary care function of care coordination across multiple settings and clinicians.

Despite a strong evidence base, primary care faces many challenges. Graduates of US medical schools are not choosing to specialize in primary care, raising concerns about workforce capability in a system with an expanded reliance on

primary care. New physicians' decreased interest in primary care careers coincides with increasing indebtedness for medical trainees, the ever-widening gap in salaries between primary care and specialist physicians, an exponential increase in primary care functions, and burnout among practicing physicians called on to deliver more and more services in less and less time.<sup>6</sup>

Nurse practitioners, physician assistants, and other health care professionals are well poised to provide many aspects of primary care, although these alternatives have met with some resistance within organized medicine and face inconsistent regulatory policies among states. More widely accepted is the notion of team-based care, in which physicians share responsibility with nurses, care coordinators, patient educators, clinical pharmacists, social workers, behavioral health specialists, and other team members. Although the role of well-trained primary care physicians to manage complex care for patients with multiple comorbid conditions is difficult to dispute, evidence is insufficient to inform current policy debates about the ideal staffing of a primary care practice.

**Patient-Centered Care.** The second cornerstone of the PCMH model is patient-centeredness, or the tailoring of care to meet the needs and preferences of patients. The PCMH model urges active engagement of consumers and patients at all levels of care delivery, ranging from shared decision-making to practice improvement. This involves a significant cultural change from viewing patients as passive recipients of information to being more active, prepared, and knowledgeable participants in their care. There is need for greater use of shared decision-making tools to assess patient preferences for different treatment options. Improving cultural competence among clinicians is critical.

In addition, the PCMH model emphasizes patient-centeredness in the broader sense, placing the patient at the center of the health care system by expanding access and improving options for patient-clinician communication, such as use of the Internet for electronic "visits." In this way, pro-

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vision of primary care can extend beyond the 4 walls of the traditional examination room and beyond traditional bankers hours, for a variety of patient populations.

**New-Model Practice.** The third cornerstone of the PCMH model, loosely defined as “new-model practice,” represents a departure from 20th-century “business-as-usual” health care models. Building on innovations emerging from the relatively recent era of continuous quality improvement, patient safety, transparency, and accountability, 21st-century practices are called on to incorporate evidence-based processes of care, including population-based care management facilitated by patient registries, performance measurement and improvement, point-of-care decision support, and information technology. Certain aspects of this new-model practice are based on solid evidence; other aspects are too new to have been adequately studied.<sup>7</sup>

National data from 2006-2007 demonstrated that insufficient practice infrastructure exists to support widespread implementation of the PCMH model.<sup>8</sup> Generally speaking, early adopters were more likely to be large medical groups (greater than 140 physicians) and those owned by large entities with greater resources. In Massachusetts, increased PCMH capabilities were associated with large practice size and network affiliation.<sup>9</sup> Perhaps the greatest challenge to reform of the health care delivery system is that 32% of US physicians practice solo or in 2-person partnerships, and 60% practice in settings of 50 physicians or fewer.<sup>10</sup> Some of the physicians in these smaller practices are eager to implement change but lack the resources to do so. Others will choose retirement rather than transform their practice.

Specification of the correct mix of external incentives (eg, performance measurement and reporting requirements) and additional payment and internal practice support (eg, new staffing models, learning collaboratives, and clinical information technology) to stimulate widespread transformation remains elusive. The solution may lie in networking practices to form larger organizational entities with access to greater resources. A variety of different approaches have been proposed, including making use of existing hospital medical staff organizations, second-generation physician-hospital organizations, and virtual interdependent networks of physician practices.<sup>11-13</sup>

A key component of new-model practice is electronic clinical information technology. If introduced correctly, interoperable electronic health records (ie, those freely permitting data exchange between systems) can facilitate coordination, increase efficiency, and potentially improve health outcomes. If introduced without sufficient patience, planning, training, and resources, information technology will simply add cost to the system, clutter to practices, and frustration to isolated and overtaxed primary care clinicians. The Obama administration has invested \$19 billion to stimulate the implementation of clinical information technology. Success hinges on doing so in a coordinated fashion,

with the establishment of interoperability standards and adequate technical and other support for small and isolated physician practices.

**Payment Reform.** The final cornerstone of the PCMH model is payment reform. The model outlines a payment structure that combines fee-for-service, pay-for-performance, and a separate payment for care coordination and integration. The payment structure is explicitly intended to provide compensation for care coordination, care management, and medical consultation outside the traditional face-to-face visit. The model also calls for financial recognition of case-mix differences, the adoption and use of clinical information technology for quality improvement, savings from reduced hospitalizations, and the achievement of quality targets. Case-mix adjustment is particularly important, because practices functioning as PCMHs could attract patients with complex chronic illnesses and multiple comorbid conditions. These practices should be appropriately compensated to address such adverse selection.

Although paying primary care physicians for their services both within and beyond the office visit is essential, the size and nature of the incentives that will drive total practice transformation is not known. Payment reform may need to be more aggressive and comprehensive than proposed, including clear alignment of incentives between primary care physicians, specialists, and hospitals. Primary care cannot be addressed in a vacuum; ultimately, the focus should be on rewarding those who contribute to high-quality, cost-effective care across the continuum, regardless of specialty or venue.

### Additional Challenges

Each of the 4 cornerstones of the PCMH model has its unique strengths and vulnerabilities. Three additional challenges to the success of the model must be considered. First, standard measurement criteria must be developed to designate practices that function as PCMHs. The National Committee for Quality Assurance (NCQA) has already provided leadership in this area. Building on its substantial experience with accrediting and certifying health care organizations, the NCQA has developed a voluntary program for PCMH recognition.<sup>14</sup> However, the initial NCQA standards have been criticized for overemphasizing the measurement of information technology infrastructure and inadequately crediting practices for delivering on other aspects of the model, such as developing continuous healing relationships and improving the patient experience. Developing measures of care that reflect experiences and relationships, rather than infrastructure and processes, presents an important challenge to the status quo in performance measurement and reporting. Multistakeholder involvement is required to develop standard measures that accurately represent the PCMH model so that the PCMH definition is not limited by existing measurement tools.

Another important challenge to the success of the PCMH model is public perception. For some, “medical home” sounds like a nursing home or evokes comments such as “first you go to the medical home, then you go to the funeral home.”<sup>15</sup> In addition, primary care remains stigmatized by the “gatekeeper” image of the managed care era, and primary care physicians would be better framed more as personal physicians or navigators. Furthermore, any health reform effort in the United States that aims to decrease costs risks being perceived as restricting access to quality. Concerted educational and communication initiatives are needed that clearly describe the PCMH model using language and examples that resonate with the US public. The model then needs to deliver on its promises of delivering high-quality, coordinated care that is truly patient-centered.

Furthermore, the expectation of short-term cost savings may be unrealistic in many markets. Implementation of the PCMH model will require infrastructure investment and retooling in the primary care practice. It will require thousands of individual clinicians and practices to develop new business models and new staffing structures, to incorporate new tools and technologies, and to engage in new ways of working with health plans, consumers, and patients, while continuing the daily work of providing patient care. If savings are to be accrued under the PCMH model, they will come, for example, in decreased redundancies, decreased medical errors, decreased emergency department visits and hospitalizations for ambulatory care sensitive conditions, decreased rehospitalizations for patients recently discharged, and prevention of costly complications. Evaluation of the model will be key, allowing for sufficient time to elapse before drawing definitive conclusions. A criticism of current pilot demonstration evaluations is the pressure on researchers to demonstrate a business case, or lack thereof, in short order. In this regard, health care reform may do well to heed the lessons of the recent collapse of the financial sector: remaining too focused on short-term gains is alluring but in the end may prove foolhardy.

## Conclusion

Marketplace and political realities will necessitate action on delivery system reform before evidence is available to determine the optimal course of action. Built on the 4 cornerstones of primary care, patient-centered care, new-model practice, and payment reform, the widely endorsed PCMH model has the potential to increase access and quality and to decrease the rate of growth in costs over time. As health care reform gains momentum, the strength of the PCMH model is about to be tested.

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## REFERENCES

1. Patient-Centered Primary Care Collaborative Web site <http://www.pcpcc.net/index.php>. Accessibility verified April 2, 2009.
2. Patient-centered primary care pilot projects guide. Patient-Centered Primary Care Collaborative Web site. <http://www.pcpcc.net/content/pcpcc-pilot-projects-guide>. Accessibility verified April 2, 2009.
3. Demonstration projects & evaluation reports: Medicare demonstrations. Centers for Medicare & Medicaid Services Web site. <http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1199247>. Accessibility verified April 2, 2009.
4. American Academy of Family Practice. State Medical Home legislation. <http://www.trendtrack.com/texis/app/viewrpt?event=483e340d376>. 2008. Accessed September 2, 2008.
5. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457-502.
6. Lee TH, Bodenheimer T, Goroll AH, Starfield B, Treadway K. Perspective roundtable: redesigning primary care. *N Engl J Med*. 2008;359(20):e24.
7. Rosenthal TC. The medical home: growing evidence to support a new approach to primary care. *J Am Board Fam Med*. 2008;21(5):427-440.
8. Rittenhouse DR, Casalino LP, Gillies RR, Shortell SM, Lau B. Measuring the medical home infrastructure in large medical groups. *Health Aff (Millwood)*. 2008;27(5):1246-1258.
9. Friedberg MW, Safran DG, Coltin KL, Dresser M, Schneider EC. Readiness for the Patient-Centered Medical Home: structural capabilities of Massachusetts primary care practices [published online ahead of print December 3, 2008]. *J Gen Intern Med*. 2009;24(2):162-169. doi:10.1007/s11606-008-0856-x.
10. Liebhaber A, Grossman JM. Physicians moving to mid-sized, single-specialty practices. *Track Rep*. 2007;(18):1-5.
11. Shortell SM, Casalino LP. Health care reform requires accountable care systems. *JAMA*. 2008;300(1):95-97.
12. Fisher ES, Staiger DO, Bynum JP, Gottlieb DH. Creating accountable care organizations: the extended hospital medical staff. *Health Aff (Millwood)*. 2007;26(1):w44-w57.
13. Fisher ES. Building a medical neighborhood for the medical home. *N Engl J Med*. 2008;359(12):1202-1205.
14. PPC-Patient-Centered Medical. National Committee for Quality Assurance Web site. <http://www.ncqa.org/tabid/631/Default.aspx>. Accessibility verified April 2, 2009.
15. Ross M, Igus T, Gomez S. From our lips to whose ears? consumer reaction to our current health care dialect. *Permanente J*. 2009;13(1):8-16.