

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.

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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

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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 patient-centered care: (1) respect for the patient's values, preferences, and expressed needs; (2) information and education; (3) access to care; (4) emotional support to relieve fear and anxiety; (5) involvement of family and friends; (6) continuity and secure transition between health care settings; (7) physical comfort; and (8) coordination of care.⁷ The U.S. health care system is often deficient in many of these core attributes.

For example, a 2007 Commonwealth Fund survey studied the effect on patients of having access to an "enhanced" regular provider, which they called a "medical home." The patient survey used four indicators to measure the extent to which adults have a medical home: (1) having a regular doctor or place of care; (2) experiencing no difficulty contacting the provider by telephone; (3) experiencing no difficulty getting care or medical advice in evenings or on weekends; and (4) having physician office visits that are well organized and run on time. The survey found that when the four characteristics are combined, only 27 percent of working-age adults have a well-functioning medical home.⁸ Similarly, more recent research has suggested that failures in care coordination are common and can create serious quality concerns.⁹

A seven-country cross-national patient survey recently found that having a medical home that is accessible and helps coordinate care is associated with significantly more positive patient experiences. The U.S. health system performed at or near the bottom on many of these measures.¹⁰ Yet, on most available measures and assessments of patient-centeredness, some practices are able to attain the desired performance, despite the lack of specific financial support for many aspects of patient-centered care.

■ **The challenge of chronic care.** According to a recent analysis, virtually all Medicare spending growth from 1987 to 2002 could be traced to beneficiaries who were treated for five or more conditions.¹¹ Given the perceived cost and quality problems related to patients with chronic conditions, many approaches to improving care for these patients—variously called "disease management," "chronic care management," and "case management"—have been tried. A main problem with these approaches is that they commonly operate independently rather than in conjunction with physician practices, functioning either on a referral basis or in parallel with primary care rather than being integrated within or closely aligned with the practice.¹² For example, third-party disease management typically has relied on nurses in call centers interacting with patients mostly by phone. Recent pilot tests of third-party disease management in Medicare seem to have failed to reduce spending or improve

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 has not yet been scaled for broad adoption in more typical practices.¹⁶ Given the growing challenge of managing chronic disease and the unimpressive record of approaches that do not include physician practices, the impulse to see the CCM implemented in a PCMH as the primary source of care coordination and management for chronic care patients is natural, especially given evidence of success of some of the CCM's constituent elements in randomized controlled trials (RCTs).¹⁷

■ **Relatively poor primary care compensation.** Recent attention has focused on the current lack of interest among graduates of U.S. medical schools in primary care careers.¹⁸ This reluctance has been attributed partly to the relatively low reimbursement that PCPs receive from Medicare and private payers.¹⁹ Although policy analysts have pointed to flaws in how Medicare fees are calculated and have recommended approaches that would redistribute reimbursement toward primary care, without major legislative intervention to change the way the Medicare physician fee schedule is structured and maintained, the primary care share of Medicare and commercial plan spending will likely continue to decline.²⁰

Faced with political and marketplace-driven difficulties of reorienting fee schedules toward primary care, the medical home can be viewed as an alternative way to recognize and support primary care activities, particularly those that are not considered to be part of evaluation and management (E&M) service codes that qualify for reimbursement under standard Medicare and private payer payment policies. These include non-visit-associated patient communication, coordination with other clinicians and community agencies, and supporting patients in self-management. Designating a medical home eligible to receive supplemental payments for these activities provides a potential way around the zero-sum, budget-neutral mindset that governs how fee schedules are set and that works against primary care. Further, proponents argue that if properly supported, primary care, which currently receives about 7 percent of health care expenditures, can help reduce the remaining 93 percent; that is, that additional spending on medical homes represents an investment that will pay dividends.²¹

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.

■ **Pediatric medical home.** The AAP introduced the “medical home” in 1967 as a way to improve the care of children with special health care needs, estimated to account for about 13–18 percent of children.²² In 2004 the AAP added an operational definition that lists three dozen specific activities that should occur within a medical home, many oriented around fostering care coordination for this subpopulation of children and youth. Although there is some indication that care in pediatric medical homes has improved outcomes for special-needs children and reduced parents’ missed workdays, the evidence for the cost-saving potential of the pediatric medical home is not robust; barriers to successful implementation have been identified, including lack of time and staff and high costs, which typically have not been supported with additional compensation.²³

■ **Primary care.** A separate evolutionary track to the PCMH was the identification and promotion of primary care as a distinct practice domain. Meeting at Alma Ata, Kazakhstan, in 1978, the World Health Organization (WHO) endorsed the central role of primary care, declaring that it “is the first level of contact of individuals, the family and community within the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing care process.”²⁴ The core elements of primary care emphasize first-contact care; responsibility for patients over time; comprehensive care that meets or arranges for most of a patient’s health care needs; and coordination of care across a patient’s conditions, care providers, and settings.²⁵ As demonstrated by Barbara Starfield’s group, evidence of the effectiveness and cost-saving potential of these specific attributes is extensive at the individual and population levels; the strong implication is that attributes of effective primary care should apply to all patients, not just to subpopulations of patients with special needs or chronic conditions.²⁶

Many managed care programs adopted the approach of having PCPs assume the central care coordinating role, viewed positively as a “primary care case manager” or pejoratively as a “gatekeeper,” limiting patients’ access to desired care to save money. Although these types of requirements are in some decline in the face of the backlash against managed care, many insurers still require a subscriber to select a PCP to serve as the entry point into the health care system.²⁷

In Medicaid, the primary care case management model was oriented more to helping recipients gain access to care; it has had some success and is being expanded toward more fully conceived medical home approaches. For example,

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 to the existing focus on patient-centeredness.

■ **Practice redesign.** The end of the twentieth century brought a surge of interest in the potential of electronic medical records (EMRs) and related information technologies to improve quality, safety, and efficiency. Although the core elements of primary care can be accomplished using less well-developed practice resources, the hope is that they can be more reliably carried out with EMRs and multidisciplinary teams, as described in the CCM. Proponents believe that PCPs who adopt EMRs would be able to perform care management and coordination activities that they had not been able to do well when using paper. Electronic registries would enable physicians to more effectively address population health—for example, calling in patients overdue for specific preventive interventions. Decision-support software embedded in EMRs would promote better adherence to clinical practice guidelines. When EMRs were being promoted earlier in this decade, the emphasis on encouraging patient self-management of chronic conditions and other concepts built into the CCM were separately endorsed for adoption in primary care settings.

■ **Evolution to the PCMH.** By the middle of this decade, the various currents—pediatric medical homes, patient-centered primary care, EMRs, and the CCM—were synthesized in a proposal for what its authors called “A 2020 Vision of Patient-Centered Primary Care.”²⁹ This particular vision provided balance between the traditional attributes of primary care and the newer opportunities for improving care through the adoption of various IT functions and CCM-based practice redesign.

Concurrently, a number of initiatives to promote primary care practices' use of advanced health IT capabilities, including EMRs, were begun, including the General Electric–initiated Bridges to Excellence. Within the past year, the NCQA began a formal Practice Recognition program for the PCMH, derived from the Physician Practice Connections (PPC) standards that had emphasized health IT and the CCM.³⁰ With the endorsement of the four specialty societies and many other supporters of the PCMH, the NCQA's PPC-PCMH standards have become a basic tool adopted by some payers, including Medicare, in proceeding with demonstrations of the medical home concept.

To a large extent, the CCM was the blueprint for the NCQA's Recognition Standards. However, Wagner and colleagues assumed that the CCM would be developed on a solid platform of primary care.³¹ Accordingly, the CCM did not explicitly delineate the more traditional attributes of primary care, such as round-the-clock access and coordination with other providers. Some believe that these

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-PCMH 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.

It might not be by chance that most attempts to adopt the CCM have occurred in relatively large organizations, such as multispecialty group practices.³³

■ **Practice size and scope.** Even if solo and small group practices had the will and were provided the resources to incorporate elements of the PPC-PCMH standards, they might not have the ability to manage many of the recommended elements. Although qualifying as a basic medical home does not strictly require an EMR, many of the standards assume that practices will be using them for many functions. Yet the per patient costs of an EMR are higher for smaller practices than for larger ones, and the expertise to choose and implement an EMR might not be available; similarly, a small practice might not have enough diabetic patients to efficiently use the time and expertise of a diabetes educator.

About 33 percent of physicians are in practices of one or two physicians, and 42 percent, five or fewer, with only a slight trend in recent years toward larger practices.³⁴ Although many solo and small group practices have adopted EMRs, other components of the PPC standards might not be feasible in small practices.

Indeed, practices participating in the Ideal Medical Practice initiative, which effectively eliminates the need for any practice staff, appear to be demonstrating that very small practices that make the commitment can meet many of the goals of the medical home using EMRs but without adopting the formal team approach that is integral to the CCM and called for in the NCQA recognition standards.³⁵

Thus, there appears to be a need to define PCPs' participation in "virtual organizations," with the practice taking on the more traditional patient-centered primary care roles and working with other entities to provide some of the elements envisioned in the CCM. In this way, the primary care practices can be responsible for patient-centeredness for all patients in the practice and can work within a larger, community-based team to address the special needs of patients with chronic conditions, mental health problems, or other subpopulations.

In another approach, called Guided Care, a registered nurse (RN) in a practice with several physicians provides targeted chronic care management to fifty to sixty patients with serious chronic conditions. Relying on an EMR that is specialized for these patients, the Guided Care RN collaborates with the patient's PCP to manage elements of the CCM and specifically target clinical problems seen in the frail elderly, such as depression and hearing loss.³⁶ Preliminary evidence suggests that this "streamlined" approach doesn't require major practice redesign; however, efficient use of the dedicated Guided Care RN would usually require the number of chronic care patients served by several physicians.³⁷

■ **Patient populations served by the medical home.** There remains a lack of agreement about whether the PCMH is designed to target subpopulations, as the pediatric medical home does. The endorsing primary care specialty societies and NCQA recognition standards assume that adoption of the medical home would affect care for every patient served by the practice, whereas the legislation for Medicare's Medical Home demonstration targets a subgroup of high-cost, complex Medi-

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.

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