In the Literature

Highlights from Commonwealth Fund-Supported Studies in Professional Journals

A House Is Not a Home: Keeping Patients at the Center of Practice Redesign

September 10, 2008

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Journal: *Health Affairs*, September/October 2008 27(5):1219–30

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Full text is available at:
http://content.healthaffairs.org/cgi/content/abstract/27/5/1219?ijkey=00Ajo9Vs7yvo.&keytype=ref&siteid=healthaff

Synopsis

Based on a literature review and interviews with physicians, researchers identified ways in which medical homes could address problems facing the health care system, such as reimbursement inequities, and discussed prerequisites for medical home implementation.

The Issue

The patient-centered medical home (PCMH) has been broadly defined as a practice providing care that is “accessible, continuous, comprehensive and coordinated and delivered in the context of family and community.” While the definition is widely accepted, advocates of the PCMH model may have different expectations and emphases. Broad consensus on what medical homes can reasonably expect to accomplish and how they can be best supported will be necessary for wider adoption.

> “[A]dditional spending on medical homes represents an investment that will pay dividends.”

Key Findings

Tracing the Medical Home’s Evolution

- The American Academy of Pediatrics introduced the medical home in 1967 as a way to improve the care of children with special health care needs. In 1978, the World Health Organization endorsed the central role of primary care, emphasizing consistent and comprehensive care over time and coordination of care across conditions, providers, and settings.
- By the end of the 20th century, electronic health records (EHRs) had generated interest because of their ability to help primary care physicians perform care management and coordination activities.

- By the middle of this decade, the various components of the model were synthesized and introduced in a Commonwealth Fund-authored article, "A 2020 Vision of Patient-Centered Primary Care." Bridges to Excellence, the National Committee for Quality Assurance, and other organizations initiated programs to advance PCMH activities.

Improving Care, Controlling Costs

- A seven-country survey found that having an accessible medical home that helps coordinate care is associated with more positive patient experiences.
- Much of the growth in recent health care spending is associated with patients with multiple chronic conditions. Primary-care-based disease management models that highlight multidisciplinary teams and informed patients have shown success in improving care and reducing costs.
- Recent medical school graduates have expressed little interest in primary care careers, partly due to relatively low reimbursement rates. The PCMH model may help to recognize and support primary care activities.

Facing Challenges

- Busy physicians—particularly those in small practices—operate under tremendous time constraints and resist changes that initially take away from time with patients.
- Managing resources will be challenging for small and solo practices, even if they have the will to adopt the PCMH model. For instance, the per-patient costs of implementing an EHR system are higher for smaller practices; similarly, a small practice may not have enough diabetic patients, for example, to warrant adding a diabetes educator to staff.
- Implementation and operation of PCMHs requires management capability and physician leadership, as well as the capacity to develop processes and IT systems. These conditions will present challenges for any practice, regardless of size.

About the Study

The authors conducted a literature review and spoke with numerous physicians and policy experts.

The Bottom Line

PCMH may be a transformative innovation—for some practices now, but for many others only in the long run. Proponents of the model should be careful not to alienate physicians by overemphasizing the adoption of more challenging elements, like EHRs, and by not focusing on crucial aspects of patient-centered care.

Citation

R. A. Berenson, T. Hammons, D. N. Gans et al., "A House is Not a Home: Keeping Patients at the Center of Practice Redesign," *Health Affairs*, Sept./Oct. 2008 27(5):1219–30.

This summary was prepared by Deborah Lorber.