The Patient-Centered Medical Home Movement: Why Now?

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JAMA. 2010;303(16):1644-1645 (doi:10.1001/jama.2010.524)

http://jama.ama-assn.org/cgi/content/full/303/16/1644

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CONFIDENCE IS INCREASING THAT THE PATIENT-centered medical home model of primary care can be a strong foundation for a high-performing US health care system. The medical home concept was first described in 1967 by the American Academy of Pediatrics, and medical homes have been demonstrated as the most effective way to care for children with special needs.[1] Less is known about the model's effectiveness in caring for patients of all ages. There is robust evidence that primary care–based systems produce higher quality at more affordable costs[2] and help to level health disparities that come with social disadvantage. But the United States does not have a viable primary care–based health care system.

Much can be learned from recent events leading to the emergence of the medical home as one of today's most hoped for solutions to the US health care crisis. "Why now?" Because this may be the United States' teachable moment. The medical home movement, which is addressing problems that have long inhibited the development of a flourishing primary care system, can provide access to care for more Americans and stem rapid growth in costs.

One major challenge is the need to maintain a viable primary care workforce. Coincident with increasing evidence that primary care–based systems benefit patients, the United States seemed poised to recommit resources to primary care in the early 1990s. However, following the subsequent demise of health reform efforts in the 1990s and the ensuing backlash against managed care, the attractiveness of primary care careers steadily waned. With an aging population, the proportion of patients needing complex care for one or more chronic illnesses increased, one of many factors creating more demands on primary care clinicians' time. Primary care practice became less financially viable than specialty care. As a result of such changes, primary care was considered to be in serious decline.[3,4]

Meanwhile, a body of research was under way to develop better chronic illness care through the Chronic Care Model. This design principle supports self-management, providing patients with skills and access to a prepared, proactive clinical team aided by information technology and community resources.[5] Ideally, chronic care management is centered in primary care. However, according to the Institute of Medicine's (IOM's) "Quality Chasm" reports,[6] US health care is increasingly fragmented and moving away from principles of primary care and chronic care management, despite evidence of their effectiveness.

Even integrated delivery systems—termed "accountable health care organizations"[7] and credited with providing better integrated, less fragmented care—are often challenged to provide high-quality, affordable primary care. Group Health—a Seattle-based nonprofit health insurance and care delivery system that has always been primary care–based—is one example. In response to market forces and perceptions that ready access to physicians and other clinicians of choice was a problem in traditionally managed health maintenance organizations, Group Health in 2002 implemented a primary care redesign. Elements included same-day appointments, open access to specialists, and an electronic medical record with a secure Web site that enabled members to e-mail their physicians and view their individual patient records. The redesign also established ambitious productivity standards and reimbursement changes for primary care clinicians.

Even though the initiative met patient expectations for improved access to care and increased clinicians' productivity, clinical quality did not improve. Moreover, primary care clinicians experienced dramatic negative effects on their quality of life. By forcing physicians to work harder and faster, the redesign created unrealistic demands and made primary care less sustainable.[8] In response, many physicians either reduced their clinical commitment (so-called clinical full-time equivalent) or retired early. Thus, even in an integrated system with innovations such as the Chronic Care Model, the full benefits of primary care were not being realized.

That challenge prompted another step in primary care redesign: the introduction of the patient-centered medical home. In 2006, Group Health selected a prototype clinic as a "proof of concept" to test the value of the patient-centered medical home. This clinic included 8 physicians and 9200 patients. The model required substantial investment to reduce physician panels from approximately 2300 to 1800 patients and to expand standard visit time from 20 to 30 minutes. Staffing levels were increased for other mem-

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bers of the health care team. These changes—all built around maintaining continuous healing, care-providing relationships—allowed clinicians more time with patients and were complemented by planned increases in telephone and e-mail encounters as an alternative to in-person visits. In addition, the clinic instituted daily heath care team "huddles," previsit chart review, and patient-centered quality deficiency reports.

After a year, there were early and broad-based improvements. Compared with controls, patient care experience, clinician work experience, and clinical quality of care improved.[9] Substantial up-front investments to support the revitalizing effort were recouped largely due to fewer emergency department and urgent care visits.[9] Ambulatory care–sensitive hospitalizations were also decreased.[9]

Based on these results, Group Health is now investing considerable resources to implement the medical home in all 26 of its primary care clinics. Improvements in patient experience, quality of care, and reduced clinician burnout have been sustained over 2 years in the prototype clinic. Patients continue to experience fewer emergency department visits and reduced hospitalizations due to ambulatory care–sensitive conditions. In addition, recruitment and retention of clinicians, both primary and specialty care, have improved.

However, many questions remain. How will the medical home scale up to Group Health's 26 primary care centers, each with unique features? How adaptable is the model for smaller practices, safety net clinics, and solo practices outside systems like Group Health? How essential is the advanced electronic medical record with its shared patient portal and secure messaging? Can the model work in environments in which clinicians are not reimbursed for comprehensive services beyond the standard face-to-face visit?

Medicine must evolve to become more responsive to patient needs, including the complex needs of patients with chronic illness. The medical home allows time for clinic teams to prepare for visits and negotiate the agenda and provides resources for patient self-management and care that happen beyond traditional office visits. The medical home also promotes improved access, pointing to solutions for delivery of quality care and access in an organized, affordable way.

Some may suggest that the medical home—like the Chronic Care Model—is just good primary care, and they are right. However, primary care is complicated and is increasingly becoming even more so, such that delivery of high-quality primary care within traditional care settings is becoming burdensome and challenging for clinicians.

Thus, Group Health's early medical home experience suggests that patient-centered medical homes can be an effective model for primary care, but only if health care organizations and systems invest resources, rethink reimbursement, and redesign care teams to address the comprehensive and increasingly complex needs of an aging population.

Financial Disclosures: Dr Reid reported that he is a shareholder and receives salary support from Group Health Permanente, the physician group affiliated with Group Health Cooperative. Dr Larson reported no financial disclosures.

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