ON TRACK

Transformation to the Patient-Centered Medical Home

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The voices commenting online since the last issue of *Annals* are strong, vibrant, and grounded in deep experience.

Ian McWhinney[1] calls for generalist physicians to:

…honour the first principle of general practice (family medicine). The principle is that whatever problem our patients bring to us, we will never say: "I don't do this." If I think you need a specialist, I will find an appropriate specialist for you, but whatever he or she does for you, I still will be your doctor.

My commitment to you is not just to look after one particular illness, but to care for you as a person, whatever problem you may have. As a patient said to me once: "I want a doctor who specializes in me."

For our relationship to work well, I ask you to call on me or one of my colleagues for all your needs. If you feel that a specialist is required, I will be pleased to advise you as to the best one. The most important level is the generalist (or family medicine), which [is] concerned with relationships. We don't have specialties (except as a side interest). A functioning generalist level makes things much easier for the specialist level.

If we fail to honour the first principle, we will break up into one hundred pieces, and general practice will die.

Could it be that we are not teaching the first principle?

Commenting on an exploration of the value of practice ownership, one of a series of essays by David Loxterkamp, Gayle Stephens[2] notes:

Physicians, especially family physicians, have lost more control of their professional ideals and virtues to employers than ever they lost to government, and that despite our pervasive fear of socialized medicine; a fear so entrenched that family physicians individually and collectively are all but silent about health care reforms under debate currently. The question for me is whether the current family physician workforce admires, wants and is qualified to follow in Dr. Loxterkamp's footsteps. If the answer is "yes," they need to mobilize themselves in their own best interests. If "no," we all need to make the ideals real again. We need to recover the moral credibility that accrued to our account from physicians who lived and worked in real communities for a long time. Commuters, transients, and day-laborers are unlikely ever to know their patients so well or be trusted as much.

There will be no point in creating medical homes that lack families. Who will be father and mother among the professional staffs? Who aunts, uncles and cousins? I can imagine a medical home morphing into a Dickensian orphanage, without mothers and fathers, and in their places Mr. and Mrs. Bumble, Fagan, Bill Sykes and the Artful Dodger—and Oliver Twist will still be singing "Where is Love?"

The Healing Pool at Bethesda is being troubled again as it was in 1993. Then it was poisoned by Harry and Louise. This time, "Everybody In!"

Kurt Elward exemplifies those ideals in his response to a study on declining trends in the provision of prenatal care. He describes delivering a baby girl and handing it to a grandmother with whom he had diagnosed and prayed and abided through a prior serious illness. "As I drove home at 3 AM, I realized I have one of the best lifestyles in the world."[3]

Balancing this dramatic moment with the overarching lessons of a series of essays by David Loxterkamp, Johanna Shapiro[4] notes that:

…authentic, satisfying meaning in doctoring becomes less about the "big" dramatic moments, the thrilling saves in the ER, and more about "small" things—connections, shared conversations…the secret of living well is not always in having all the answers but in pursuing unanswerable questions in good company.

Shapiro[4] further notes that:

…the moral authority of the physician derives less from her expert knowledge (though this is obviously an essential foundation of doctoring) than from her emotional connection, commitment, and caring. [Loxterkamp] is also wise enough to realize that, to use theological terminology, the redemption and salvation that may be found in the patient-doctor relationship belong not only to the patient, but to the doctor as well.

Balancing the soaring rhetoric and experience of this essay series[5-8] and accompanying editorial,[9] Thomas Schwenk[10] asks rhetorically:

…whether the physician-patient relationships described [in the editorial and essays] are means to an end, or ends onto themselves. Is building the relationship itself, in all of its complexity and glory, the fundamental professional goal of family physicians, or is the relationship, however deep and powerful, merely a means to provide patient-centered, evidence-based medical care of the highest quality?

I suspect both authors would endorse the latter, but also suspect that they may secretly wish for the former.

It is the degree to which family medicine is unclear about this critical distinction that is the degree to which our ultimate success will be compromised. I worry that family physicians define themselves too frequently according to their success in building relationships (frequently measured in terms of how "nice" we are in contrast to how "un- nice" other physicians and the system are), and too little in terms of our ability to deliver the highest quality of medical care as measured by the subtle and intricate balance of patient values and biomedical outcomes.

The patient-centered medical home is still a relationship-centered means to deliver medical care, not a medical office whose fundamental purpose is to build relationships.

Howard Stein attempts to resolve the dilemma of relationships as means or end, by paraphrasing Kant: "means are always part of ends."[11] Stein goes on to remind us that evidence from narratives, relationships, and reflection is different from and complementary to rational-scientific canons of evidence.[12]

Saul Weiner points to his research and experience in using this sort of contextual evidence to guide the complex decisions that are not amenable to guidelines that come from the usual sources of evidence.[13]

Trisha Greenhalgh[14] and Howard Brody[15] note that a generalist approach[16] is important in common as well as in complex illnesses. Brody notes that "the generalist way, more focused on relationship than on disease, is actually the only rational way to approach the patient."

Ann Reichsman[17] and Trisha Greenhalgh[14] describe how this contextual, relationship-based information is developed over time if its importance is valued and supported. Reichsman[17] writes:

It is often hard for patients to understand that by seeing the same provider at each visit, no matter how amenable the presenting complaint might be to a brief visit with "whoever is available," they are creating a relationship which may in the future be lifesaving. As primary care providers, we often ask our staff to accomplish two contradictory tasks at the same time. We want to satisfy our patients' desire to be seen as soon as possible, but we also want to make sure that they see their own provider, not the physician or nurse practitioner who is the first available. By helping our receptionists and schedulers understand the mission of primary care we can make use of their potential as members of the health care team.

The largest online discussion since the last issue related to this question of how to organize practice and health care reform.[18] The voices of 4 family physicians on the vanguard of the country's first National Demonstration Project of the Patient-Centered Medical Home (PCMH)[19] amplify the lessons drawn by an independent evaluation team.

Susan Andrews observes that the timeframe for expectations is shorter than the reality even in highly motivated, functional practices with a technological head start. "Our experience was that it took about 2 years to fully reap the benefits of an EHR financially and several years longer to see marked improvements in quality."[20] After 8 years of working on the technological aspects of the patient-centered medical home [PCMH], she notes[20]:

Our focus now is to work on the "patient-centered" part of the home—keeping what patients want and their overall satisfaction at the hub of our decision-making processes. Our healthcare system is broken. There is great potential for both huge savings and improved population health if the PCMH is implemented by the majority of primary practices, as demonstrated by our practice. Demonstration projects can help point us in the right direction, but if the wrong conclusions are reached, society could miss out on an important opportunity to help people live longer, more productive lives.… My hope is that the majority of physicians will focus on the advantages [of the PCMH] and begin their own transformations processes.

Susan Wilder notes that despite many transformative changes in her practice, "at the end of the day, we are still waiting for our payers to value even ONE of these wonderful patient-centered, value-added services.… It has become increasingly clear that every system is "payer centric" and thus the only way to have truly "patient-centered" care is to eliminate the middle man and work directly for the patient who is the arbiter of value and quality."[21]

Robert Eidus[22] notes that "although transformation is difficult, it is doable," but it needs to be supported by "priming of the pump with up front payment for structure and process enhancement."

William Harrington[23] observes that:

A lot of inertia holds this great concept back. The illusiveness of a brand identity for PCMH impedes promotion. Researchers question the value of PCMH. Overworked primary care physicians lack time, energy and financial incentives to try it. Insurers worry of its effects on their profits. PCMH pilots may be too brief to demonstrate value.

Harrington goes on to say, however, that the "PCMH is an essential step to rescue medical care and make primary care a desirable specialty again: one in which we can once again not only treat our patients, but care for them too."

In contrast to the cautious optimism of these practice change pioneers, software vendor David Morin[24] notes that the pressures on practices makes many take a "robotic response" to "running down the checklist" of technology features required to qualify as a PCMH.

Greg Paulson[25] of the National Committee for Quality Assurance (NCQA) notes that the NCQA is "committed to revising and improving the PPC-PCMH [their qualification tool] based on empiric findings from early PCMH and PCMH-like demonstration projects."

Other policy- and practice-relevant commentaries in this active discussion[18] come from Gordon Schiff, Katie Coleman, Stephen Schoenbaum, Larry Green, Joseph Scherger, Paul Grundy, Thomas Rosenthal, and Martin Sepulveda.[26-33]

In response to these comments and to reports of distortions of study findings in both the media and congressional testimony, the lead author of the National Demonstration Project report sums up some of the early policy lessons[34]:

• The PCMH movement is not just blowing smoke. The changes required of even highly motivated, well-supported practices becoming PCMHs are truly transformative!

• True transformation takes time and resources, but if we want healthcare to really be different from the current dysfunction, transforming primary care and building the larger system on this foundation is what will be required.

• President Obama has talked about the need to take a long-term perspective, even as we work on the immediate steps. The analysis by our team supports taking immediate action but with a longer term perspective on what it takes to make truly transformative change.

• After devaluing the primary care function for the past decade, we now need to reinvest in helping it to build itself as the foundation of a high value, accessible, personalized health care system.

• It is likely that we will see more of the kind of misrepresentation that we saw in those distorting the our recent report, as those who have profited from the system dysfunction realize that resources will need to be shifted away from them and toward building up the primary care function that is fundamental and essential to a functional, high value health care system focused on fostering health for all rather than on creating wealth for some.

Many of these comments are highly referenced, providing additional depth. All are richer than the snapshots presented here. Other articles in the last issue stimulated shorter but similarly deep discussions. I encourage those interested in these topics to read these valuable comments and join the debate at http://www.AnnFamMed.org.

References

1. McWhinney IR. The first principle [eletter]. http://www.annfammed.org/cgi/eletters/7/2/100#10745, 10 Apr 2009.
2. Stephens G. Who works in whose home [eletter]? http://www.annfammed.org/cgi/eletters/7/3/264, 26 May 2009.
3. Elward KS. Have we given up "We deliver" to Dominoes [eletter]? http://www.annfammed.org/cgi/eletters/7/2/128#10902 , 30 May 2009.
4. Shapiro J. A fortunate family physician [eletter]. http://www.annfammed.org/cgi/eletters/7/3/261#10906, 3 Jun 2009.
5. Loxterkamp D. Doctors' work: eulogy for my vocation. *Ann Fam Med*. 2009;7(3):267-268.
6. Loxterkamp D. The old duffers' club. *Ann Fam Med*. 2009;7(3):269-272.
7. Loxterkamp D. The dream of home ownership. *Ann Fam Med*. 2009;7(3):264-266.
8. Loxterkamp D. A change will do you good. *Ann Fam Med*. 2009;7(3):261-263.
9. Marnocha M. What truly matters: relationships and primary care. *Ann Fam Med*. 2009;7(3):196-197.
10. Schwenk TL. What truly matters: high quality medical outcomes [eletter]. http://www.annfammed.org/cgi/eletters/7/3/196#10806, 14 May 2009.
11. Stein HF. The common log on the rising river [eletter]. http://www.annfammed.org/cgi/eletters/7/3/261#10820, 15 May 2009.
12. Stein HF. Evidence and other appetites [eletter]. http://www.annfammed.org/cgi/eletters/7/3/196#10872, 22 May 2009.
13. Weiner SJ. The generalist approach: an unmeasured dimension of physician performance [eletter]. http://www.annfammed.org/cgi/eletters/7/3/198#10904, 31 May 2009.
14. Greenhalgh T. More ways of thinking and doing [eletter]. http://www.annfammed.org/cgi/eletters/7/3/198#10792, 14 May 2009.
15. Brody H. The generalist: keeping score [eletter]? http://www.annfammed.org/cgi/eletters/7/3/198#10788, 13 May 2009.
16. Stange KC. The generalist approach. *Ann Fam Med*. 2009;7(3):198-203.
17. Reichsman AB. The generalist and health care reform [eletter]. http://www.annfammed.org/cgi/eletters/7/3/198#10822, 15 May 2009.
18. TRACK discussion in response to: Nutting PA, Miller WL, Crabtree BF, Jaen CR, Stewart EE, Stange KC. Initial lessons from the first national demonstration project on practice transformation to a patient-centered medical home. *Ann Fam Med*. 2009;7(3):254-260. http://www.annfammed.org/cgi/eletters/7/3/254. Accessed Jun 8, 2009.
19. Nutting PA, Miller WL, Crabtree BF, Jaen CR, Stewart EE, Stange KC. Initial lessons from the first national demonstration project on practice transformation to a patient-centered medical home. *Ann Fam Med*. 2009;7(3):254-260.
20. Andrews ST. Focus on the good news [eletter]. http://www.annfammed.org/cgi/eletters/7/3/254#10874, 22 May 2009.
21. Wilder SS. Proceed with caution [eletter]. http://www.annfammed.org/cgi/eletters/7/3/254#10882, 25 May 2009.
22. Eidus R. What will it take going forward [eletter]? http://www.annfammed.org/cgi/eletters/7/3/254#10854, 18 May 2009.

23. Harrington WG. Whatever it takes [eletter]. http://www.annfammed.org/cgi/eletters/7/3/254#10844, 17 May 2009.

24. Morin DJ. Transform first, technology second [eletter]. http://www.annfammed.org/cgi/eletters/7/3/254#10861, 20 May 2009.

25. Pawlson G. Caveat venditor [eletter]. http://www.annfammed.org/cgi/eletters/7/3/254#10827, 17 May 2009.

26. Schiff GD. Break or brake [eletter]. http://www.annfammed.org/cgi/eletters/7/3/254#10878, 22 May 2009.

27. Coleman K. Real redesign required [eletter]. http://www.annfammed.org/cgi/eletters/7/3/254#10868, 22 May 2009.

28. Schoenbaum SC. Two of many important lessons [eletter]. http://www.annfammed.org/cgi/eletters/7/3/254#10864, 22 May 2009.

29. Green LA. The PCMH genie is NOT going back in the bottle [eletter]. http://www.annfammed.org/cgi/eletters/7/3/254#10856, 18 May 2009.

30. SchergerJ. Great recommendations for the patient-centered medical home [eletter]. http://www.annfammed.org/cgi/eletters/7/3/254#10839, 17 May 2009.

31. Grundy PH. Misunderstood-by the press and the policy makers [eletter]. http://www.annfammed.org/cgi/eletters/7/3/254#10834, 17 May 2009.

32. Rosenthal T. Evaluations are essential [eletter]. http://www.annfammed.org/cgi/eletters/7/3/254#10775, 13 May 2009.

33. Sepulveda M-J. Caveat venditor [eletter]. http://www.annfammed.org/cgi/eletters/7/3/254#10784, 13 May 2009.

34. Nutting PA. Re: misunderstood-by the press and the policy makers [eletter]. http://www.annfammed.org/cgi/eletters/7/3/254#10852, 18 May 2009.

CORRECTION

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Buetow W, Kiata L, Liew T, Kenealy T, Dovey S, Elwyn G. Patient error: a preliminary taxonomy. *Ann Fam Med*. 2009;7(3):223-231.

An error was made in Table 2. Taxonomy of Patient Error in which the entry for the row heading "Mental errors: background determinants" was inadvertently labeled "Memory errors: background determinants." A corrected Table 2 is available at: http://www.annfammed.org/cgi/content/full/7/3/223/DC2.