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There's No Place Like Home: Moving Towards Patient-Centered Medical Homes for Healthcare Reform

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"The health of the people is really the foundation upon which all their happiness and all their powers as a state depend."

-Benjamin Disraeli

The Census Bureau revealed that more than 50 million people, approximately one in every six Americans, were uninsured in 2009.[1] Alarmingly, between the years 2008 and 2009, the percentage of uninsured individuals increased from 14.6 percent to 15.1 percent, meaning that 2.2 million more people were uninsured in 2009.[2] Many factors contributed to this decline of insured Americans, including jobs lost in the recession, companies no longer sustaining health insurance benefits for their employees, and the need for families to eliminate coverage in an effort to save money.[3]

The overwhelming increase in medical care costs precipitated the rise in the number of Americans without health insurance.[4] In 2009, employees paid 47 percent more than they did in 2005 for their family health coverage, while employers paid 20 percent more for family health coverage.[5] Individuals in low-income households were nearly three times as likely to be uninsured as those with incomes of $75,000 or more.[6] The Census Bureau's data reflects the pervasive healthcare problem Americans continue to face and

1. Richard Wolf, *Number of Uninsured Americans Rises to 50.7 Million*, USA TODAY (Sept. 17, 2010, 2:19 PM), http://www.usatoday.com/news/nation/2010-09-17-uninsured17_ST_N.htm.
2. *Census Bureau Releases 2009 American Community Survey*, U.S. CENSUS BUREAU (Sept. 28, 2010), http://www.census.gov/newsroom/releases/archives/american_community_survey_acs/cb10-cn78.html.
3. Wolf, *supra* note 1.
4. *Id.*
5. *Id.*
6. *Id.*; *Income, Poverty and Health Insurance Coverage in the United States: 2009*, U.S. CENSUS BUREAU

highlights the very motivation for the passage and enactment of the PPACA of 2010.

I. INTRODUCTION

In response to the growing epidemic of uninsured Americans, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010.[7] The PPACA was designed to insure an additional 32 million individuals in both public and private programs.[8] Since its passage, the PPACA has been at the epicenter of contentious partisan debates.[9] To illustrate, the House of Representatives voted 245 to 189 in support of repealing the PPACA, led by the Republican majority opposed to its passage.[10] Despite the ongoing political clash with regard to the PPACA's passage, it has created a platform for serious discussions about how to remedy the healthcare crisis and ultimately create opportunities that would reach as many uninsured and insured Americans as possible.

One such proposed remedy that has garnered growing support is the Patient-Centered Medical Home (PCMH). The PCMH is a healthcare approach aimed towards "providing comprehensive primary care for children, youth, and adults."[11] Namely, it operates under the presumption that the patient's entire healthcare needs will be provided by the patient's individual physician.[12] This article will evaluate PCMHs as a viable solution for healthcare reform. Specifically, this article will: (1) explain how PCMHs relate to the PPACA; (2) explore the components and unique characteristics of PCMHs; (3) proffer reasons for their growing support; (4) assess the risks and concerns that members of varying communities have about PCMHs; and (5) show evidence that PCMHs can, in fact, operate successfully.

A healthcare system failing nearly one in six Americans is clearly an urgent matter.[13] With so many Americans struggling to afford their healthcare benefits in the current economic climate, it is no wonder that the community at large is currently engaging in

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(Sept. 16, 2010), http://www.census.gov/newsroom/releases/archives/income_wealth/cb10-144.html.

7. Wolf, *supra* note 1.

8. *Id.*

9. *See generally* David M. Herszenhorn & Robert Pear, *House Votes for Repeal of Health Law in Symbolic Act*, N.Y. TIMES (Jan. 19, 2011), http://www.nytimes.com/2011/01/20/health/policy/20cong.html.

10. *Id.*

11. *Joint Principles of the Patient Centered Medical Home*, PATIENT CENTERED PRIMARY CARE COLLABORATIVE (Feb. 2007), http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home.

12. *Id.*

13. Wolf, *supra* note 1.

discussions about how to remedy this problem. . .quickly.

A seemingly top contender, the PCMH, has received much attention after the passage of PPACA's Section 3502, which establishes community health teams to support the PCMH.[14] Significantly, PPACA provides $11 billion to support and expand community health centers over the next five years.[15] Section 3502 directs the Secretary of Health and Human Services to create a program that either provides grants or directly enters into contracts with "eligible entities" to establish health teams to provide primary care services.[16] These "eligible entities" are referred to as health teams in Section 3502 whose purpose will be "to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas" they serve.[17] Community health centers have existed for over 40 years, providing "comprehensive, high-quality preventive and primary health care to patients regardless of their ability to pay."[18] Throughout this time, community health centers have effectively become the PCMH for millions of Americans, including some of the country's most vulnerable populations.[19] The implementation of community health centers will, therefore, play a crucial role in testing the PPACA's overall success.[20]

II. WHAT ARE PCMHS?

The model home concept, while new in the wake of recent healthcare reform discussions, is actually not a novel idea.[21] In fact, the American Academy of Pediatrics (AAP) first introduced the term "medical home" in 1967.[22] The term, medical home,

14. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3502, 124 Stat. 119, 124 (2010) [hereinafter PPACA].

15. *Community Health Centers and the Affordable Care Act: Increasing Access to Affordable, Cost Effective, High Quality Care*, HEALTHCARE.GOV (last updated Aug. 6, 2010), http://www.healthcare.gov/news/factsheets/increasing_access_.html [hereinafter *Community Health Centers and the Affordable Care Act*].

16. PPACA, *supra* note 14.

17. *Id.* (noting that health teams are comprised of "community-based interdisciplinary, inter-professional teams").

18. *Community Health Centers and the Affordable Care Act*, *supra* note 15.

19. *Id.*

20. *Id.*

21. *Joint Principles of the Patient Centered Medical Home*, *supra* note 11.

22. *Id.*; ROBERT GRAHAM CENTER, THE PATIENT CENTERED MEDICAL HOME: HISTORY, SEVEN CORE FEATURES, EVIDENCE AND TRANSFORMATIONAL CHANGE (Nov. 2007), http://www.graham-center.org/online/etc/medialib/graham/documents/publications/mongraphs-books/2007/rgcmo-medical-home.Par.0001.File.tmp/rgcmo-medical-home.pdf.

initially referred to a centralized location for archiving a child's medical record.[23] Since then, the AAP has expanded the medical home concept to include primary care that is "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."[24] In 2004, the Future of Family Medicine Project sought to expand the meaning of a medical home and promoted the idea that every American should have a personal medical home.[25] There are currently four primary care physician organizations that encourage the use of PCMHs: the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association.[26] The practice of PCMHs has also been endorsed by many purchaser, labor and consumer organizations, including IBM, Merck and Company, the ERISA Industry Committee, and AARP.[27] In fact, major public and private health plans, including Medicare, United Health Care, Aetna, and certain Blue Cross and Blue Shield plans are testing PCMHs.[28]

PCMHs are defined by six characteristics which include: "(1) personal physician, (2) physician-directed medical practice, (3) whole-person orientation, (4) coordinated care, (5) quality and safety, and (6) enhanced access."[29] In the PCMH model, the personal physician's role is to ensure that his or her "patients have access to coordinated and managed care that is continuous, comprehensive, preventive, and evidence-based."[30] The PCMH model ensures that each patient is "assigned to a team of health care professionals who are responsible for that patient's ongoing care."[31] The personal physician directs and oversees the team, and specifically provides the patient with "acute, chronic, and preventive care."[32]

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23. *Joint Principles of the Patient Centered Medical Home*, *supra* note 11.
24. *Id.*
25. Gwendolyn Roberts Majette, *From Concierge Medicine To Patient-Centered Medical Homes: International Lessons & The Search For A Better Way To Deliver Primary Health Care In The U.S.*, 35 AM. J.L. & MED. 585, 593 (2009).
26. *Id.*
27. Robert A. Berenson et al., *A House Is Not A Home: Keeping Patients At The Center Of Practice Redesign*, 27 HEALTH AFF. 1219 (2008).
28. *Id.*
29. Majette, *supra* note 25, at 586.
30. *Id.*
31. *Id*. at 593.
32. *Id.*

III. PCMH MODEL BENEFITS

PCMHs offer myriad benefits, including improved coordination, broader access, and patient-centered care. In a 2005 survey, the Commonwealth Fund discovered that only thirty-six percent of primary care physicians systematically received patient survey data that would provide valuable feedback pertaining to patients' preferences, needs, and values.[33] The lack of communication between patient and physician is one of many reasons in support of adopting the PCMH model.

The core of the PCMH model is that it is patient-centered primary care. The PCMH model stresses the importance of primary care. Acknowledging that this kind of care is individualized for the patient, the patient is provided easier access to a physician who can offer a broad range of services.[34] This could potentially lead to greater success with respect to prevention and overall health.[35] Notably, patient-centered primary care is integral to a healthcare system that ensures that all of the patients have access to the kind of care that works for them.[36] The Picker Institute "has delineated eight dimensions of patient-centered care, including: (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."[37] Much of what has been missing in our current system has been consistent and reliable communication and the PCMH is a direct response to that problem. In support, numerous studies have indicated that through a PCMH model, the overall healthcare costs are reduced.[38] Further, these studies simultaneously show that patients' overall care improves in situations where patients have continual access to preventative and maintenance care.[39]

Additionally, PCMH supporters contend that patients will benefit from integration and

33. Karen Davis et al., *A 2020 Vision of Patient-Centered Primary Care*, 20 J. GEN. INTERNAL MED. 953, 953 (Oct. 2005), http://onlinelibrary.wiley.com/doi/10.1111/j.1525-1497.2005.0178.x/pdf.

34. Paul A. Nutting et al., *Initial Lessons From the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home*, 7 ANNALS FAM. MED. 254, 259 (2009).

35. *Id.*

36. Davis et al., *supra* note 33, at 953.

37. *Id.*

38. JULIE E. KASS, ESQ. & JOSHUA J. FREEMIRE, ESQ., HEALTH L. HANDBOOK §3:16 (Alice G. Gosfield ed., 2009).

39. *Id.*

coordination of care.[40] Specifically, enhanced technology will create a system structured more efficiently.[41] By using enhanced technology, personal physicians anticipate that the integration of a patient's medical history, documentation, and testing will afford the physician more time to meet with his or her patients.[42] Care coordination would provide that specialist care providers communicate with primary care physicians to ensure that the patient receives prompt feedback so as to make appropriate and informed decisions regarding their care.[43] Essentially, this would require systems to be capable of monitoring whether recommended referrals actually occurred, ensuring that specialist consultation reports quickly reach the primary care physician, thus minimizing any delay in diagnosis and/or treatment.[44]

Another crucial characteristic and intended benefit of PCMHs is that patients would receive better access to care.[45] A more efficient and streamlined system, both with respect to infrastructure and general care provider coordination, would allow patients more flexibility in making appointments and generally having their primary care physicians readily accessible whenever needed.[46] Consequently, greater access would promote patient engagement in care.[47] Signs of patient engagement in care would include patients' receipt of information regarding their condition and subsequent treatment options.[48] Providing a system that encourages patients to participate in their care allows patients to have a greater chance for successful self-care.[49]

IV. RISKS AND CONCERNS REGARDING PCMH IMPLEMENTATION

While the PCMH model has garnered growing support as a powerful vehicle for healthcare reform efforts, it is a solution that concerns some healthcare professionals. The American Academy of Family Physicians commenced the National Demonstration Project (NDP) in 2006 to test the PCMH model.[50] After the NDP's conclusion in 2008,

40. *Id.*
41. *Id.*
42. *Id.*
43. Davis et al., *supra* note 33, at 954.
44. *Id.*
45. *Id.*
46. *Id.*
47. *Id.*
48. *Id.*
49. *Id.*
50. Nutting et al., *supra* note 34, at 254-55.

the independent evaluation team assessing the NDP's effectiveness in implementing the PCMH model reported several preliminary issues.[51] The team noted that there was a serious risk in underestimating the magnitude and time-frame that would be required to implement the required changes to reflect the PCMH model.[52] The team also raised concerns about the overestimation regarding the information technology sophistication necessary for successful implementation.[53] Further, the team was concerned with the severe undercapitalization to support and sustain PCMHs.[54] Raising these concerns early, the evaluation team aspired to caution the professional community against prematurely adopting unrealistic expectations surrounding PCMHs and their successful implementation.[55] Additionally, the goal in raising these concerns early was to avoid jeopardizing the evolution of the PCMH.[56]

As noted by the independent evaluation team for the NDP, becoming a PCMH requires transformation.[57] The changes that are required in adopting a PCMH model cannot occur incrementally, but instead, demand that participants wholly adopt an entirely new model of operation. Notably, "the NDP experience suggests that transformation to a PCMH requires a continuous, unrelenting process of change. It represents a fundamental reimagination and redesign of practice, replacing old patterns and processes with new ones."[58] As with any new venture, change from past practices and procedures takes time to successfully implement. Some fundamental changes required to successfully adopt the PCMH model would include:

> . . .new scheduling and access arrangements, new coordination arrangements with other parts of the health care system, group visits, new ways of bringing evidence to the point of care, quality improvement activities, institution of more point-of-care services, development of team-based care, changes in practice management, new strategies for patient engagement, and multiple new uses of information systems and technology.[59]

The team argues that each component cannot stand on its own, thus asserting that all of

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51. *Id.* at 255.
52. *Id.*
53. *Id.*
54. *Id.*
55. *Id.*
56. *Id.*
57. *Id.*
58. *Id.*
59. *Id.*

the abovementioned components of the PCMH model are interdependent.[60] Consequently, time becomes an important factor in the overall discussion surrounding PCMH adoption. The team opines that for legitimate PCMH implementation, everyone in the medical practice will have to be engaged in the process.[61] It is reasonable to expect that because of the need for mass PCMH support, it will inevitably take time before effective PCMH implementation can realistically be attained.

As part of the necessary transformation, PCMHs require more sophisticated technological programming than is currently in place. Some of the greatest weaknesses in implementing the PCMH model lie in the current absence of an infrastructure to support its ongoing existence.[62] Specifically, this means the systems currently used do not allow physicians to quickly document each patient's ongoing relationship with their primary care physician.[63] The system also fails to allow practitioners to document "that a personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients."[64] Further, it is an impediment that the current system fails to allow physicians to document that "a personal physician is responsible for providing for all of the patient's health care needs or takes responsibility for appropriately arranging care with other qualified professionals."[65] Finally, the system as it exists today, does not document that the care a patient receives is coordinated and/or integrated in the context of the entire health care system and in the patient's community.[66] These current deficiencies are exactly what the independent evaluation team assessing the NDP noted: the lack of transformation when moving towards a PCMH model.[67] A medical home adhering to the core principles requires ". . .developing processes and systems (including IT) to support high levels of access and for 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

60. *Id.*
61. *Id.* at 258.
62. John C. Rogers, MD, MPH, MEd, Commentary, *The Patient-Centered Medical Home Movement – Promise and Peril for Family Medicine*, 21 J. AM. BD. FAM. MED. 370, 371 (2008).
63. *Id.*
64. *Id.*
65. *Id.*
66. *Id.*
67. Nutting et al., *supra* note 34, at 255.

performance, and support for evidence-based decision making."[68]

An additional concern regarding medical homes is the undercapitalization of the current model.[69] Fully integrating PCMHs requires a fundamental change in providing patient care and with this type of transformation in the system comes a cost. As mentioned above, information technology will play a vital role in the existence and sustainability of medical homes.[70] The cost of advanced health information and software technology concerns medical professionals.[71]

Despite genuine interest and commitment to incorporate PCMH standards into their practices, some physicians, namely solo and small group practices, may not have the ability to manage the recommended elements of a PCMH model.[72] One specific concern relates to the use of electronic medical records (EMR).[73] Although the use of an EMR is not an absolute requisite when adopting the PCMH model, many of the standards relating to PCMH implementation assume that practices have and will use an EMR.[74] The issue, though, is that patient costs of an EMR are higher for smaller practices than they are for larger practices.[75] Consequently, smaller practices may not be in a position to implement an EMR as their standard practice, thus potentially causing a barrier for smaller practices to satisfactorily fully adopt the PCMH model.[76] In fact, approximately thirty-three percent of physicians are in practices of one or two physicians, and approximately forty-two percent of physicians' groups are comprised of five or fewer, noting that there has only been a slight trend toward physicians joining larger groups.[77] An added concern for PCMH implementation is that by moving "so decisively to emphasize new responsibilities that implicitly assume reliance on various EMR functions [. . .], current PCMH recognition standards may leave behind crucial aspects of patient-centered care and the physicians who provide it."[78] Despite this concern, however, providers of Medicare and Medicaid could potentially benefit from the EHR incentives offered in the

68. Berenson et al., *supra* note 27, at 1227.
69. Nutting et al., *supra* note 34, at 255.
70. *Id.*
71. Berenson et al., *supra* note 27, at 1226.
72. *Id.*
73. *Id.*
74. *Id.*
75. *Id.*
76. *Id.*
77. *Id.*

HITECH Act.[79] By using the incentive payments allocated for satisfactory use of EHR technology, providers could potentially make progress towards a PCMH model.

An additional concern relates to the lack of a general consensus regarding the PCMH's objective.[80] Some advocates insist that the PCMH should focus on a commitment to formal shared patient-physician decision making.[81] Other advocates "see the medical home as better able to identify particular clinical areas that deserve greater attention, such as unexpressed depression or alcohol dependence."[82] Alternatively, others believe that the PCMH is an opportunity to address the need for greater attention to health literacy.[83] A further complication is that the role of hospitals in PCMHs has not yet been identified.[84]

Despite the various concerns related to mass acceptance and integration of the PCMH model, there are signs that such a model can work. Many fundamental characteristics of patient-centered primary care practices already exist in Denmark.[85] Each Danish primary care physician has an ongoing population of approximately 1,500 patients.[86] Danish primary care experts stress the importance of the ongoing relationship between patients and the primary care physicians because they opine that the contracts between them leads to better care as a result of both parties involved being aware of their rights and responsibilities.[87]

A primary care practice in Oregon, the Chehalem Medical Clinic, has implemented the medical home approach, whereby a team at the Clinic reviews patients' records before each visit to ensure that all necessary tests, immunizations and other preventive care is current.[88] Further, the Clinic staff communicates by secure e-mail and via phone in order

78. *Id.* at 1228.

79. Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, 123 Stat. 467 (2009) [hereinafter HITECH Act].

80. Berenson et al., *supra* note 27, at 1227.

81. *Id.*

82. *Id.*

83. *Id.*

84. AMERICAN HOSPITAL ASSOCIATION COMMITTEE ON RESEARCH, PATIENT-CENTERED MEDICAL HOME AHA RESEARCH SYNTHESIS REPORT 11 (Sept. 2008), http://www.hret.org/patientcentered/resources/patient-centered-medical-home.pdf.

85. Davis et al., *supra* note 33, at 955.

86. *Id.*

87. *Id.*

88. Joe Rojas-Burke, *'Medical Home' Strategy Aims to Boost Quality, Cut Costs with Better Primary Health Care*, OREGONLIVE.COM (Feb. 10, 2011, 11:26 AM), http://www.oregonlive.com/health/index.ssf/2011/02/medical_home_strategy_aims_to.html.

to ensure streamlined care.[89] The EMR tracks patients, which is particularly beneficial in situations where patients require multiple medications and follow-up care.[90] Other signs that Oregon is moving towards medical homes is that Kaiser Permanente, the largest managed care organization in the United States, "aims to convert all of its clinics in Oregon and southwest Washington to the medical home model" within the next year.[91] In addition to Kaiser Permanente's intended efforts, other leading PCMH advocates in Oregon "include the Oregon Primary Care Association and nonprofit health plan CareOregon, which helped [fifteen] community health centers and safety-net clinics across Oregon secure a grant from the Commonwealth Fund to establish medical homes."[92] Further, an Oregon House committee considered a bill which proposed that the committee would provide $400,000 to establish a PCMH research and training center at Oregon Health & Science University.[93]

V. CONCLUSION

The growing support for PCMHs arises from the need to implement a system that has greater accessibility to a wider population. With rising costs for healthcare and health insurance, the sense of urgency to find a solution to this impending problem becomes more prevalent the longer it is left unaddressed. Advocates of the PCMH model strongly assert that implementation would not only lead to a new healthcare identity, but would also combat the deficiencies in our current system. While advocates raise legitimate concerns pertaining to a sweeping adoption of the PCMH model, they still seem to trust that by carefully adhering to this model, by respecting the time it will take and the funding it will require, this model has the potential to sustain more than just a temporary existence. Perhaps, then, community health centers' continued and consistent success is appropriate indicia that PCMHs not only have the potential for similar national impact, but will, in fact, create a new healthcare identity for the U.S. that will have the greatest national reach thus far.

89. *Id.*
90. *Id.*
91. *Id.*
92. *Id.*
93. *Id.*