

The Shaky Foundation of the Patient-Centered Medical Home

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The patient-centered medical home (PCMH) is viewed as an idea whose time has come. In theory, the PCMH enables better primary care centered on a more defined relationship between primary care physicians (PCPs) and patients, team-based primary care service delivery, enhanced care coordination and access to primary care, and improved quality through the use of disease registries and health information technology.¹ Integral to the PCMH model is added payment for PCPs to help compensate them for enhanced care coordination, as well as to fund the personnel and technology-related investments needed in the practice to do medical home-type care.

Proponents assert that the PCMH makes sense for a healthcare system that is fragmented, impersonal, and overly focused on high-cost specialty care. With demonstration projects under way nationally, they hope that implementation of the model can show enough quality improvement and cost savings to ensure its long-term survival. But something important is missing in the current medical home debate. Little serious attention is being paid to whether implementation of the medical home model can help solve several key problems already transforming our current primary care system, or if the model will succumb to these problems despite evidence that it works.

One key problem involves the retention and growth of the primary care workforce. Primary care careers remain grossly unappealing to the vast majority of US medical students. For example, over the past 5 years, existing family medicine residency slots have been filled annually with US medical school graduates 45% of the time or less, despite declines in the total number of positions available.² In addition, a recent survey showed that only 24 of 1177 fourth-year medical students intended to pursue careers in general internal medicine.³ These realities on the front end of PCP supply are bad enough. But we also see an increasingly large older cohort of PCPs who, even if they enthusiastically embrace medical home-type care as proponents suggest, will exit active practice in the next decade in numbers that cannot be matched by those coming into the field.

If we are to believe common wisdom, insufficient compensation and undervaluing of primary care services in the healthcare marketplace are significant causes of the primary

care recruitment problem. Yet these reasons oversimplify the reality. For example, it is hard to imagine how an extra \$30,000 or \$40,000 per year—optimistic estimates of what enhanced PCMH reimbursement can deliver to individual PCPs—will suddenly spur vast numbers of medical students to enter a generalist specialty such as internal medicine, family medicine, or pediatrics, which remain lower paying than almost all other medical specialties. Add to this the reality that primary care careers have a serious image problem among the medical student cohort, and it gets easier to suggest that the recruitment issue could undermine rather than be positively impacted by the medical home model.

A second hypothesis to explain the recruitment problem is that profound value shifts have occurred in the medical student cohort. As much as money, they want the choice of a career that gives them flexibility and the ability to have a life outside of work.^{4,5} Many want a job with defined work boundaries. The cultures of many medical schools and residency programs do not promote primary care as a viable career choice for young medical students or residents. Within a training system geared to turning out specialists, a primary care career is increasingly perceived by many medical students as a “consolation prize” that involves a diffuse knowledge base, less intellectual rigor, and more everyday hassles than other careers like emergency and hospital medicine, or specialties like dermatology or radiology, all of which pay more than primary care and provide a “nine-to-five”-like workday.^{4,6}

In fact, such perceptions may not be valid in the real world of primary care practice. However, the negative perceptions also are fueled by the fact that PCPs no longer have complex work like procedural medicine and hospital medicine within their occupational grasp and struggle with incorporating new types of complex work like behavioral healthcare into crowded workdays. The decreasing presence of PCPs in the hospital also lessens the exposure of medical students to everyday primary care, further promoting the negative stereotypes noted above.

Proponents of the PCMH argue that the medical home ideal

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will give medical students more of what they desire in their careers, including sufficient compensation and greater work-life balance. But what if the opposite ends up to be true? What if effective medical home implementation in the average primary care practice exacerbates practice pressures and generates a negative image of primary care? It is possible, at least in the beginning, that some of the medical home principles put into practice could force PCPs to work longer and harder, without significant new compensation, particularly if they still have to pay the bills by continuing the existing business model of large numbers of face-to-face office visits. Within such a model, where assembly-line medicine is the norm, there will be fewer opportunities to build in the extended, patient-centric care offered by the PCMH. Innovations such as the use of integrated care teams that make maximum use of all the practice's human resources may help alleviate the workload. But adopting a team-based clinical approach in a busy practice is not easy, does not always work in intended ways, and may require additional financial investment that practices operating under a razor-thin profit margin might be reluctant to make.

Will young physicians with a different value set than their older cohorts see a more complicated primary care job (even if it involves roles for the PCP such as "team leader" and "care manager") as something that (1) still doesn't pay enough for the work required and (2) remains more life wrecking than other specialties that are "neat and clean" in their job and task structures? And can PCPs, especially younger ones, fulfill the varied demands of a clinical care consultant, clinical team leader, or clinical care manager without ongoing exposure to a diverse array of work such as hospital medicine, the absence of which could potentially undermine the level of mutual trust in existing patient relationships and self-confidence in clinical skills, and limit access to new clinical knowledge?⁴

A second problem involves shifting consumer preferences. The notion that patients want a traditional primary care delivery system with PCPs and their practices managing their care is a bedrock assumption on which support for the PCMH rests. But it could also be posited that many patients, particularly younger, healthier ones, do not necessarily think that a physician-centric primary care system is the only one that can work for them. Many of us have now come of age in a health system where fragmented, specialty care is the norm for many of our ailments. It also is a system where medical home-type primary care has not been seen for a long time, if at all, replaced by 15- to 20-minute office visits for discrete illness episodes that provide a fast-food experience for both doctor and patient.

New, alternative forms of primary care delivery such as retail clinics are growing rapidly. These places are patronized

disproportionately by younger adults.⁷ Some early evidence points to a general public with less apprehension than might be expected in receiving care in retail clinics that often are staffed by nonphysician care providers.⁸ The idea that such places might compete effectively with traditional primary care practices on the basis of more than a few low-level clinical diagnoses is anathema to many PCPs. But what if new delivery forms like retail clinics suit a wider range of consumer needs with respect to primary care, including greater convenience and speed, as well as lower cost?

What if younger patients especially are not willing to learn about and commit themselves to the personal responsibilities required in being part of a PCMH, when many of their primary care service needs might be met cheaply and quickly while they also shop or pick up their prescriptions? What if competing forms of care like retail clinics end up poaching younger, healthier patients away from traditional primary care practices, leaving higher percentages of older, sicker patients for whom medical home-type care must be provided? Will this make implementation of the medical home model harder? Will it end up costing a lot more? If fewer younger, healthier patients actively participate in PCMHs, will that undermine some of what the model is supposed to do (ie, teach already-healthy individuals how to stay healthy) while at the same time leaving PCPs with a sicker cohort of clients in their practices who are less compliant and who require higher levels of basic acute care on a constant basis?

I do not mean to disparage the medical home concept. In an ideal primary care practice environment, it might work well. But greater attention must be paid to building a solid foundation on which to implement it. Focusing more on the primary care workforce and consumer preferences would help attend to this necessity. For instance, although many PCPs have adapted to the current business model in ways that allow them to do their work efficiently, they likely have less familiarity with true care coordination, case management, and accessible care delivery because of fewer opportunities to engage in them over the past decade or more. Many practicing PCPs will require retraining to serve as case managers, care consultants, or clinical team leaders. Young students and residents interested in primary care will need better socialization to the realities of doing primary care work that is both medical home oriented and assembly line oriented, and must know ahead of time how much is expected of them in such a bifurcated practice model. And some consumers may need extended convincing that this more intrusive model of care is worth it for them, enough so that they are willing to bypass newer, cheaper, and more convenient forms of alternative primary care delivery and place their faith once again in the traditional primary care practice.

If foundational elements like these are ignored, it strains credibility to think that the PCMH idea, which initially will complicate primary care delivery and impose stricter accountability on both doctors and patients, can provide a reliable, long-lasting hinge to swing a major component of the US health system in a more patient-centric direction.

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REFERENCES

1. **Patient-Centered Primary Care Collaborative.** Joint principles of the patient centered medical home. <http://pcpcc.net/content/joint-principles-patient-centered-medical-home>. Accessed October 16, 2009.
2. **American Academy of Family Physicians.** National Resident Matching Program. 2010 Match Summary and Analysis. <http://www.aafp.org/online/en/home/residents/match.html>. Accessed May 25, 2010.
3. **Hauer KE, Durning SJ, Kernan WN, et al.** Factors associated with medical students' career choices regarding internal medicine. *JAMA*. 2008;300(10):1154-1164.
4. **Hoff T.** *Practice Under Pressure: Primary Care Physicians and Their Medicine in the Twenty-First Century*. Piscataway, NJ: Rutgers University Press; 2009.
5. **Dorsey ER, Jarjoura D, Rutecki GW.** Influence of controllable lifestyle on recent trends in specialty choice by US medical students. *JAMA*. 2003;290(9):1173-1186.
6. **Block SD, Clark-Charelli N, Peters AS, Singer JD.** Academia's chilly climate for primary care. *JAMA*. 1996;276(9):677-682.
7. **Mehrotra A, Wang MC, Lave JR, Adams JL, McGlynn EA.** Retail clinics, primary care physicians, and emergency departments: a comparison of patients' visits. *Health Aff (Millwood)*. 2008;27(5):1272-1282.
8. **Deloitte Center for Health Solutions.** Retail Clinics: Facts, Trends and Implications. http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_RetailClinics_230708%281%29.pdf. Accessed October 18, 2009. ■