PERSPECTIVE

The Patient-Centered Medical Home For Chronic Illness: Is It Ready For Prime Time?

Despite much enthusiasm for widespread implementation, the patient-centered medical home remains a promising approach to chronic care that awaits more data.

by Jaan E. Sidorov

ABSTRACT: Robert Berenson and colleagues caution that the patient-centered medical home (PCMH) faces many challenges. Its successful adoption will depend on its being precisely defined and demonstration that it is cost saving and scalable across varied clinical settings. Until these issues are addressed in current and upcoming pilot programs, caution about the PCMH's role in the care of people with chronic illnesses is warranted. [*Health Affairs* 27, no. 5 (2008): 1231–1234; 10.1377/hlthaff.27.5.1231]

ROBERT BERENSON and colleagues' examination of the patient-centered medical home (PCMH) cautions against unrealistic expectations for a still evolving care model.[1] Based on information from the literature and physician interviews, Berenson and colleagues give us a better understanding of the persistent cultural, management, and economic barriers standing between the PCMH and its widespread adoption.

In this Perspective I focus on these barriers, with special emphasis on chronic illness. Although the PCMH has many advantages, its approach to the ninety million Americans with chronic conditions is what conspicuously contrasts with the shortcomings of usual care.[2] The persistence of suboptimal quality and avoidable expense has prompted searches for new approaches with a proven clinical and business case.[3] Is the PCMH an answer?

Despite its advocates' enthusiasm, supportive literature, compelling anecdotes, and a National Committee for Quality Assurance (NCQA) certification program, the PCMH's adoption outside of large-group, academic, and pilot-program settings remains limited, in turn disquieting physician leaders, policymakers, politicians, and purchasers.[4] Although health system inertia and prevailing health insurers' fee schedules are factors, closer scrutiny reveals three other challenges to the PCMH's acceptance: (1) varying definitions across clinical settings, (2) doubts about its scalability, and (3) little detail about its cost-saving capabilities.

■ **Varying definitions of the PCMH.** Backed by decades of research, depictions of the PCMH and underlying medical home model and Chronic Care Model (CCM) use terms such as "coordinated," "integrated care," "enhanced access," "physician-directed teaming," and "whole-person orientation." Yet close examination of how each of these elements is actually incorporated into chronic illness care in office settings shows considerable variation in the number of elements implemented and how they are provided.[5] Published reviews of

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the medical home in clinical practice include studies with only one of the defined elements constituting medical home or the CCM.[6] Two widely cited summaries had only five of thirty-nine case studies that were able to demonstrate the presence of four of the six CCM components of community resources, health care organization, self-management support, delivery system design, decision support, and clinical information systems.[7] In response, a survey has been created to assess the degree of medical home implementation.[8] In addition, the NCQA's Physician Practice Connections–Patient-Centered Medical Home (PPC-PCMH) certification program requires not all of the PCMH's principles, such as teaming, to be present to obtain minimum credit.[9]

"There is little reason for physicians to assume that the PCMH will eventually not share the same fate as other star-crossed payment methodologies."

This flexibility is less evident in the recommended location of the PCMH's multiple care processes under a personal physician's direction. Not only is identifying a responsible physician difficult, but there also is a conspicuous lack of head-to-head studies demonstrating that the PCMH's physician-led elements perform better than similar programs situated elsewhere.[10] Hospitals, disease management (DM) vendors, and managed care organizations are already providing quality improvement, registries, care coordination, and patient coaching for chronic illness, with little evidence that relocating them adds any patient benefit. This restrictive physician-specific focus of the PCMH fails to recognize that current "back office" operations on behalf of physicians may ultimately deliver just as much value yet fail to meet the technical definition of a PCMH.

■ **Scalability.** The PCMH owes much to versions of the medical home reported in Medicaid programs, publicly funded clinics, pediatric or psychiatry care settings, and integrated care systems. In contrast, its widespread implementation in small to medium-size physician-owned sites is more subject to individual practice preferences than to loyalty to what is described in the medical literature.[11] Physician surveys on the PCMH are lacking, but one study of physicians' attitudes about patient feedback, electronic communication, and reminder systems suggests that skepticism about some of the PCMH's elements is prevalent.[12]

This is no small issue for health insurers, which have a fiduciary stake in assuring uniform access to a consistent standard of care. Advocates may hope that incomplete PCMH adoption across an insurance network can be mitigated by the voluntary shift of patients to physicians who are offering it. Not only is this unstudied, but little is known in general about the factors underlying the migration of patients with chronic illnesses among primary care sites in pursuit of quality. Furthermore, depending on the payment structure, physicians may be tempted by incentives that promote incomplete PCMH implementation or selective patient enrollment. The result could be a balkanized network of partially completed PCMH clinics.

■ **The cost-benefit ratio.** If the PCMH's central tenet is to avoid expense in chronic illness, how do the savings compare? The answer is unknown because no generalizable cost-effectiveness studies on initiatives incorporating all of the PCMH's elements exist.[13] Medicaid programs have had some success, but the combination or location of PCMH elements that reliably lead to the greatest reduction in Medicare or commercial insurance claims expense remains undefined.[14]

Although supporters suggest that the PCMH's revenue potential could halt primary care's decay, reimbursing the PCMH's direct costs is only part of the puzzle. The added indirect costs of a PCMH practice "redesign" necessary to support chronic illness care as well as the profit margins necessary to garner provider support are unknown.[15] There is also little reason for physicians to assume that the PCMH will eventually not share the same fate

as other star-crossed payment methodologies such as gatekeeping, capitation, relative value units (RVUs) and, possibly, pay-for-performance (P4P).[16] As a result, physicians may demand an additional risk premium that insures against the undercutting of their return on investment.

If the total PCMH fees ultimately demanded by physicians exceed the avoided expense for chronic illness, health insurers and payers may conclude that the costs of the PCMH are unacceptable. Advocates suggest that the diversion of existing DM fees is one solution; however, there is little indication from any PCMH pilots that insurers are prepared to abandon their investments in disease management.

ARE THE CURRENT pilot programs stops on the road to the PCMH's inevitable implementation? Despite considerable enthusiasm favoring widespread implementation, information to date suggests that the PCMH remains a promising approach to chronic care that awaits more data. How well current and future pilots address its definition, scalability, and cost savings remains to be seen. Despite its considerable merits, the PCMH remains a book that has yet to be completed. Caution is warranted before its wholesale implementation in the care of populations with chronic illnesses.

The author is chair of the board of directors of PMSLIC, a medical malpractice practice carrier domiciled in Pennsylvania. PMSLIC offers a premium discount to physicians who are certified by the National Committee for Quality Assurance's PCC-PCMH program. The views herein reflect the opinions of the author only. *The author thanks Kristin Lynn for her invaluable help in preparing this manuscript.*

NOTES

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