Discussion Paper

The Patient-Centered Medical Home: A Path Toward Health Equity?

Winston Wong, Kaiser Permanente; Karen M. Anderson, Institute of Medicine; Irene Dankwa-Mullan, National Institutes of Health; Melissa A. Simon, Northwestern University; and William A. Vega, University of Southern California*

September 2012

**Participants in the activities of the IOM Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.*

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES
Advising the nation • Improving health

The Patient-Centered Medical Home: A Path Toward Health Equity?

Winston Wong, Kaiser Permanente; Karen M. Anderson, Institute of Medicine; Irene Dankwa-Mullan, National Institutes of Health; Melissa A. Simon, Northwestern University; and William A. Vega, University of Southern California[1]

Equity was identified as one of the six core dimensions of a high-performing, high-quality health care system in the landmark Institute of Medicine (IOM) report *Crossing the Quality Chasm* (2001). The report concluded that health care should be "equitable, (that is) providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status" (p. 6).

A second IOM report, *Unequal Treatment* (2003), noted that there were pervasive examples of "differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention" and that "many sources—including health systems, healthcare providers, patients, and utilization managers—may contribute to racial and ethnic disparities in healthcare" (p. 4).

Since the publication of these two reports, an unprecedented number of initiatives to re-design the nature and objectives of the nation's health care system have been launched. While the passage of the Patient Protection and Affordable Care Act in 2010 formalized federal support for some of these initiatives, there were already a number of significant activities throughout the past decade designed to create a more effective, efficient, equitable, and patient-centered delivery model.

Notably, the concept of the patient-centered medical home (PCMH) was resurrected and revitalized. Originally promulgated by the American Academy of Pediatrics in the 1960s as an idealized set of practices to improve care for children with special needs, the PCMH was redefined and recalibrated to capitalize on the advances ushered in by, among other developments, the electronic health record and other technologically-driven advances in data management. The creation of the Patient-Centered Outcomes Research Institute (PCORI) is also emphasizing a patient-centered orientation and the need for stakeholder engagement in research.

Additionally, the consolidation of major segments of the health care system, including hospitals, multispecialty practices, and primary care also contributed to the reinvigoration of interest in the PCMH. The PCMH promises to ease fragmentation by leveraging underlying capabilities in infrastructure and data to achieve improved health outcomes and better patient experiences. Widespread adoption of the PCMH can overcome the fragmentation that has gradually eroded the relationship between physicians and their patients. Patients who are assigned to a PCMH will receive higher-quality and more effective care; this, in turn, will lead to higher patient satisfaction. In addition, the PCMH offers the tantalizing promise of reduced waste and redundancy, ultimately resulting in lower costs to the health care system.

[1] Participants in the activities of the IOM Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

Does a Focus on Care and Quality Advance a Health Equity Agenda?

A number of concurrent studies have reiterated the continued existence of widespread disparities in the quality of care experienced by socially marginalized populations (such as racial and ethnic minorities, low-income populations, the mentally ill, the elderly, and other vulnerable groups) (see, for example, the *National Healthcare Disparities Report*, 2011, which focuses on disparities relating to "racial factors and socioeconomic factors" [p. 1]). Differences in pain management, access to acute cardiovascular care, cancer screening, and hypertension control are among the recurring examples of inequity in health care experienced by African Americans, Latinos, American Indians, and Asian Pacific Islander groups. Moreover, Beal and Hernandez (2010) noted that many of these disparities are the result of differences in access to regular sources of primary care. Minority groups with regular sources of reliable primary care did not experience disparities (when compared with whites) for a number of important measures of prevention, screening, and treatment.

Could a concerted effort to establish a PCMH for marginalized, underserved groups lead to a meaningful reduction in health care disparities and result in health equity? While we await the results from evaluations of PCMH initiatives to answer this question, there have been substantial investments to promote the PCMH as the predominant model of care. The Centers for Medicare & Medicaid Services, for example, recently announced a number of grants to pilot PCMH models, and the Health Resources and Services Administration has set an ambitious aim for federally qualified health centers (FQHCs) to be formally certified as PCMH institutions.

Recent thinking about the root causes of health care disparities has cast some doubt on how effective these attempts at a PCMH model will be in narrowing the gap in health outcomes and the replicability of these models for different health care systems. Given that it is widely accepted that access to medical care may account for only 10 to 20 percent of any given individual's health status (McGinnis et al., 2002), could a delivery model, albeit one that is patient-centered, substantially affect the disproportionate burden of disease and mortality experienced by racial and ethnic minorities and other disadvantaged groups?

Health Care and Health Disparities Reflect Differences in the Social Determinants of Health

Aside from genetic factors, individual behaviors and environmental factors are postulated to account for the largest portion of influences related to population health. Health equity proponents have labeled these core facets as "the social determinants of health" and suggest that any significant attempt at eliminating health disparities, i.e., achieving health equity, must be directed "upstream" to resolve powerful and lingering social imbalances in education, housing, transportation, and access to healthy food and physical activity. This has led to federally supported efforts such as the Centers for Disease Control and Prevention's (CDC) Community Transformation Grants program and REACH grants[2] that adopt "nonmedical" approaches to address health equity and, by extension, health care disparities.

Thus, upstream strategies aim at interrupting the factors that spawn disease and poor health, and "downstream" strategies confront the inequities faced by individual patients and

[2] Ratial and Ethnic Approaches to Community Health (REACH) is the CDC's cornerstone to eliminate racial and ethnic disparities in health. http://www.cdc.gov/reach/

communities in accessing health care that is culturally competent, patient-centered, high-quality, and effective. Advocates of upstream strategies are skeptical that additional investments in medical care can change the tide of health disparities, even while conceding that *medical outcomes* might be incrementally improved if care were more patient-centered. But this logic assumes that all primary care is about "sick care," and that the patient–physician relationship has little to do with factors that ultimately result in sickness or injury (i.e., has little impact on improving the social determinants of health).

Addressing Social Determinants of Health Requires an Expanded PCMH Model

On this note, the PCMH falls upon its own sword. The problem is that the PCMH model as currently constructed adopts the prevailing paradigm of caring for patients across the *course of their disease or recovery*. Measures of PCMH performance focus on how well the practice cares for people who are sick or injured, not on how well the practice promotes wellness, health, and prevention—much less its success in intervention at the community level.

In some ways, this bifurcation is reflective of a recurring disconnection between public health and primary care. The irony is that health inequity is replicated at both the environmental ("placed-based") and point-of-care ends of the continuum. Efforts to rectify inequalities at both ends of the spectrum need to recognize the influences "at the other end," and undertake meaningful efforts to create channels that accelerate significant change. Cooperative, bridging strategies, rather than attempts to divert attention from the other camp, must be adopted. Otherwise, divergent efforts will slow down progress toward achieving health equity.

One way to move forward is to deconstruct the underlying assumptions on both ends of this continuum. For example, as currently understood, the PCMH is defined by certain salient features. The National Committee for Quality Assurance (NCQA), a prominent force in accrediting institutions as PCMHs, promotes the following as standards that must be met by medical practices in order to be recognized as a PCMH:

Table 1: NCQA PCMH Standards

1. *Enhance Access and Continuity*
2. *Identify and Manage Patient Populations*
3. *Plan and Manage Care*
4. *Provide Self-Care and Community Support*
5. *Track and Coordinate Care*
6. *Measure and Improve Performance*

SOURCE: NCQA, 2011.

These criteria capture certain "proofs" that a practice is maintaining the patient as the central focus in a physician-led system of care (NCQA, 2011). One missing element, however, is how that practice considers the context in which patients seek care, as well as the environments and social structures from which patients originate and to which they return. These environments

modulate patients' ability to adhere to treatment and gain maximum benefit from that treatment. For example, caring for a patient with hypertension who lives in an upper-income neighborhood is different from caring for a patient with the same problem who lives in the inner city.

Yet, PCMH standards as they are currently constructed seem indifferent to the ability of a practice to care for patients within the context of their community. Each community has its own set of assets and challenges that a practice needs not only to be aware of but to interact with in order to be optimally effective. The current PCMH model relates to patients narrowly, namely, as independent consumers/utilizers within a system of health care delivery, and not as members of a community. Thus, while the PCMH is focused on addressing an individual's condition, it is silent regarding influences of social and community experience that affect the course of disease and the maintenance of wellness. The model comes up short in addressing the ecological and social factors that influence an individual's ability to maintain wellness and adopt healthy behaviors.

A PCMH that confronts health inequities should also consider how it can disrupt those contributors and facilitators of poor health, including ecological and social factors, by partnering with community stakeholders and measuring the effects of its efforts on patient care and community health. A PCMH model that includes health equity as a goal should include criteria that a practice must be actively engaged in addressing the social determinants of health. Under an expanded paradigm of promoting wellness and community engagement, a PCMH could just as well be awarded for its efforts in promoting safe neighborhoods as for coordinating patient information.

Access to High-Quality Health Care Is a Social Determinant As Well

Likewise, initiatives that focus on long-term, structural solutions to address health equity come up short in addressing the needs of individuals at the point of service and as patients investing in their own self-care. Aimed squarely at stemming the disproportionate amount of resources spent on the bricks and mortar, medical equipment, technology, and drugs that fuel the escalating cost of health care, the "social determinants model" of health disparities minimizes the role of health care delivery systems, including the PCMH, in addressing the *roots* of inequity in health. Missing from the social determinants perspective is the recognition that access to high-quality health care is *in and of itself* a powerful influence on the other domains of social determinants.

More work needs to be done to identify this "third space" that is the intersection of PCMH efforts with activities taking a long-term view of the social determinants of health. For example, while it is universally recognized that educational attainment is positively correlated with average life span, poor-quality health care and access are also logically linked to lower educational achievement, and thus, health inequities. In other words, access to high-quality primary care is critical to educational opportunity, as well as fundamental for healthy citizens and communities. Similarly, access to health care plays a powerful role in determining the choices people make in where they live, and communities with access to good primary care are likely to be thriving neighborhoods. Robust primary care practices, hospitals, and medical centers contribute to the economic and social capital of communities, and can provide jobs, role models, and infrastructure that promote wellness and good health.

Creating Opportunities to Equalize Social Determinants by Investing in the PCMH

Even as our nation grapples with the waste and inefficiencies within the system that have driven health care out of the reach of 47 million people, Americans still respect and value the relationship between provider and patient. This relationship must be both fortified and redefined in order to leverage resources in both improving patient care for the frail and chronically ill and promoting community health. In light of the rapid growth of communities of color and an aging baby boomer population, the emergence of a health care delivery system that is culturally competent and reflective of diverse communities should reprioritize so that resources are allocated to wellness and prevention. We must redesign a care delivery system that is able to care for a rapidly changing demographic with different needs than those of previous generations. We must cultivate health care providers and caregivers that are aware of and informed about the biological and social factors that influence the progress of disease and wellness and can incorporate this into new practice models.

Efforts to promote the PCMH and investments in addressing the social determinants of health do not have to be mutually exclusive. There are some examples to draw from, notably the experiences of some FQHCs, as well as comprehensive models to address the needs of the frail elderly. A recent review conducted by the Institute for Alternative Futures finds that a number of clinics have implemented PCMH-related efforts, and have complemented that work with activities that engage patients and communities. Some interesting examples include clinics that have invested in improving educational opportunities for youth, improving access to affordable housing and legal services, and promoting urban farming and gardening.

We need to address the intersection of PCMH efforts with activities that take a long-term view toward addressing the root causes of inequitable health outcomes. We face immediate challenges, such as the healthy development of low-income children, reductions in obesity rates, and aging baby boomers. In each instance, primary care providers are at the front line for the delivery of care. Instances where primary care confronts the stark manifestations of community-situated deleterious factors influencing health and wellness are prime candidates for extra-clinical intervention.

For example, ensuring an adequate food supply and optimizing prenatal outcomes by minimizing exposure to violence among children (Felitti et al., 1998) are clear opportunities to address community environments that give rise to poor population health, while concomitantly improving primary care for specific vulnerable populations such as at-risk mothers and their children. Similarly, engaging communities for specific clinically significant reasons can have important secondary effects on health. Ensuring access to early prenatal care that is coordinated, patient-centered, and culturally competent can energize and activate a core group of patients, namely young mothers, to consider how they can invest in an environment that promotes the health of their families. Ultimately, it is this type of expanded "coordinated care" that supports full implementation of the PCMH and provides the framework for iterative modeling, evaluation, and refinement with the final goal of transforming the medical care system.

Predictably, the rush to build PCMH practices is motivated by the anticipation of enhanced revenue generated by payers that see the value of a more patient-oriented and coordinated system of care. Meanwhile, investments in prevention and improving social determinants rest on the belief that in the long run, people will be healthier, health outcomes will be more equitable, and the rate of health care expenditures will slow. A strategy that bridges

these two approaches would incentivize PCMH practices to play a prominent and valued role in improving communities and simultaneously promote community-level interventions that support the specific contributions medical practices make in job creation, professional mentorship, advocacy, health care access and quality of care, and infrastructure development.

A true PCMH is committed to addressing the social and environmental influences that affect patients' health and wellness, and therefore can play a key role in promoting health in a community. Patient-centeredness reminds us that we are all patients at one time or another and the activities that put us at the center of the health care environment must speak to the things that keep us well and healthy.

Suggested citation: Wong, W., I. Dankwa-Mullan, M. A. Simon, and W. A. Vega. 2012. *The patient-centered medical home: A path toward health equity?* Discussion Paper, Institute of Medicine, Washington, DC. http://iom.edu/Global/Perspectives/2012/PatientCenteredMedicalHome.aspx

REFERENCES

Beal, A., and S. Hernandez. 2010. Patient reports of the quality of care in community health centers: The importance of having a regular provider. *Journal of Health Care for the Poor and Underserved* 21(2):591-605.

Felitti, V. J., R. F. Anda, D. Nordenberg, D. F. Williamson, A. M. Spitz, V. Edwards, M. P. Koss, and J. S. Marks. 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine* 14(4):245-258.

IOM (Institute of Medicine). 2001. *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.

IOM. 2003. *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academy Press.

McGinnis, J. M., P. Williams-Russo, and J. R. Kinickman. 2002. The case for more active policy attention to health promotion. *Health Affairs* 21(2):78-93.

NCQA (National Committee for Quality Assurance). 2011. *Patient-centered medical home*. http://www.ncqa.org/tabid/631/default.aspx (accessed August 27, 2012).