

The Patient-Centered Medical Home and Nephrology

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The notion of a patient-centered medical home (PCMH) is rapidly gaining traction as the latest idea to transform health care delivery in the United States. In broad terms, PCMH is “a physician-directed practice that provides care that is accessible, continuous, comprehensive and coordinated and delivered in the context of family and community.”¹ Four primary care physician (PCP) societies, the American Medical Association and American Association of Retired Persons, numerous labor and consumer organizations, and corporations, including IBM and Merck, have endorsed the PCMH concept. Several Blue Cross/Blue Shield and private health plans, including United Healthcare and Aetna, are undertaking demonstration projects. In January 2008, the National Committee for Quality Assurance began a voluntary program to recognize medical practices functioning according to PCMH models. The Centers for Medicare and Medicaid Services (CMS) was given authority under the Tax Relief and Health Care Act of 2006 to conduct a PCMH demonstration project beginning in January 2010.

The PCMH is a model of comprehensive health care delivery and payment reform that emphasizes a central role for

primary care. Proponents believe it can improve patient care and alter the trajectory of increased health care expenditures.² Savings are projected from coordinated care, reduced emergency department visits, fewer hospitalizations, and less duplication and by incorporating increased use of the electronic medical record with the chronic care model onto a primary care platform.³ Advocates are encouraged by experience within the Medicaid program in North Carolina, where implementation of the PCMH model reportedly resulted in considerable savings. The American College of Physicians (ACP) and other societies have made PCMH a policy agenda centerpiece. Controversy has arisen among some subspecialty societies because of concerns regarding the potential for the PCMH to emulate a gatekeeper effect. Although the ACP Council of Subspecialty Societies has assiduously denied this potential, some subspecialty societies have expressed concern regarding the potentially adverse impact of PCMH on delay in timely referral, coupled with inadequate reimbursement, for certain conditions.

The American Society of Nephrology (ASN) Public Policy Board appointed a taskforce to formulate a position on the PCMH. The task force focused on identifying how nephrologists would interact with a PCMH. As a first step, the group created four case scenarios to illustrate a potential interface and to elucidate concerns that might arise with implementation (available at <http://www.asn-online.org>). The case scenarios included stage 3 chronic kidney disease (CKD), stage 4 CKD referred to a nephrologist for an initial evaluation, ESRD, and a complex autoimmune disorder requiring comprehensive management by a nephrologist and a rheumatologist but less involvement by a PCP. The task force presented these cases to an ACP physician representative for discussion and participated in the ACP Council of Subspecialty Societies PCMH Workgroup, meetings, and conference calls held by the Patient-Centered Primary Care Collaborative. Taskforce members also met with representatives from other subspecialty societies, such as the American Society of Hematology, the American College of Rheumatology, and the American Gastroenterological Society, to determine how these associations were approaching the PCMH concept.

If a physician chooses to serve as a patient’s “medical home,” then he or she receives additional remuneration for coordinating all of the patient’s care, from diet to mental health to preventive measures; however, the requirements of a medical home, including improved access and multilingual communication, comprehensive electronic data systems, detailed case management, coordination of care, performance and satisfaction reporting, cost analysis, proactive patient care self-initiatives, preventive care measures, and ongoing continuous quality improvement activities, would be daunting and perhaps unattainable for most nephrology practices.

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The consensus of the task force is that nephrologists would usually not wish to be designated as the medical home, except perhaps in cases of patients who have ESRD and are on dialysis or transplant recipients. Becoming a medical home would be possible initially only for large practices with an already established infrastructure and technological resources but could be a financial burden for smaller practices, given the necessary investment in information technology and staff to manage the coordination of care. Even large group practices are behind in adopting the PCMH model⁴; however, even if a nephrologist chooses not to serve as the medical home, the ASN PCMH Taskforce believes that he or she has the obligation to work closely with PCP so that CKD care is delivered appropriately and to ensure that specialty referrals are timely. Therefore, a clear opportunity exists to take the lead in advocating for coordinated care for CKD and defining a practical model for its implementation.

Although the concept of the PCMH is receiving considerable attention, there are a number of concerns regarding process and implementation.^{5,6} It is likely the model will be more easily adapted by large practices with sufficient financial resources to obtain certification by the National Committee for Quality Assurance. The impact of having medical groups make fundamental changes in the way they deliver care is unknown. Finally, the shortage of the current workforce in primary care in the United States will limit widespread adoption in the immediate future. Nevertheless, the quality movement will continue to grow, and the desire to improve care while reducing costs will continue to drive this effort. It is highly likely that the initial application of a medical home will extend to chronic disease management.⁷ Management of CKD fits readily into this concept, requiring close involvement of nephrologists and organizations such as the ASN in the design of paradigms in this area and consultation regarding the implementation of planned or anticipated demonstration projects.

The ASN PCMH Task Force recommends that the ASN endorse testing the PCMH concept,⁸ with the caveat that nephrologists must be involved in the creation and outline of the PCMH to ensure that patients with kidney disease continue to receive the highest possible quality of care. The ACP stresses that the idea of a PCMH is still very much evolving; therefore, the ASN and other stakeholders can provide input to optimize care models for patients with CKD, ESRD, or kidney transplants.

The task force specifically recommends that the ASN should:

1. Participate with the ACP, payers, and other health care organizations in future discussions about PCMH. Nephrologists should be eligible to become a PCMH, if they choose, for patients with advanced CKD or ESRD or after a kidney transplant.
2. Help define quality guidelines to gauge the success of a PCP as the medical home for patients with CKD. This could include the treatment of anemia, use of vitamin D, achieving BP targets, and preventing metabolic bone disease.
3. Define chronic care paths within the PCMH concept to derive a clearer paradigm for management of CKD, with emphasis on the interface between the PCP and the nephrologist as a function of CKD stage.
4. Provide input in the development of "a la carte" codes for activities such as e-mail and telephone consultations.
5. Because the PCMH concept is still being refined, it is important for the ASN to keep this issue at the forefront of its policy discussions.

The task force also offers certain precautionary comments:

1. One element of the CMS PCMH demonstration project, scheduled to begin in January 2010, is that CMS intends to share savings from the PCMH with the physician who serves as the medical home. The task force believes that this approach may create a perverse financial incentive to restrict consultation, thereby potentially decreasing the overall quality of care.
2. In a budget-neutral environment, any increase in payment to primary care could come at the expense of other medical providers and promote counterproductive and dysfunctional care strategies for the preservation of dwindling practice income. As the PCMH model has not yet been proved to improve health outcomes and coordination of care, specialist reimbursement should not be decreased to pay for PCMH initiatives.
3. Although large dialysis providers may wish to become medical homes or encourage physician groups hired by the provider to establish medical homes in their units, the ASN recommends that the medical home designation be limited exclusively to individual physicians and physician group practices.
4. Because late-stage CKD is a complex and challenging disorder that requires comprehensive case management and coordination among a number of subspecialists, providing a home relationship with a single provider may prove to be extremely arduous. The ASN will need to provide substantial direction to ensure that quality of care is maintained and that sufficient resources are provided for the management of the complications of advanced kidney disease as well as judicious planning for replacement of kidney function when indicated.

DISCLOSURES

None.

REFERENCES

1. Berenson RA, Hammons T, Gans DN, Zuckerman S, Merrell K, Underwood WS, Williams AF: A house is not a home: Keeping patients at the center of practice redesign. *Health Aff (Millwood)* 27: 1219–1230, 2008
2. American College of Physicians: Joint Principles of a patient-centered medical home released by organizations representing more than 300,000 physicians; 2007. Available at: <http://www.acponline.org/pressroom/pcmh.htm>. Accessed September 2, 2008
3. Wolff JL, Boulton C: Moving beyond round pegs and square holes: Restructuring Medicare to improve chronic care. *Ann Intern Med* 143: 439–445, 2005
4. Rittenhouse DR, Casalino LP, Gillies RR, Shortell SM, Lau B: Measuring the medical home infrastructure in large medical groups. *Health Aff (Millwood)* 27: 1246–1258, 2008
5. Sidorov JE: The patient-centered medical home for chronic illness: Is it ready for prime time? *Health Aff (Millwood)* 27: 1231–1234, 2008
6. Iglehart JK: No place like home: Testing a new model of care delivery. *N Engl J Med* 359: 1200–1202, 2008
7. Epping-Jordan JE, Pruitt SD, Bengoa R, Wagner EH: Improving the quality of health care for chronic conditions. *Qual Saf Health Care* 13: 299–305, 2004
8. Barr MS: The need to test the patient-centered medical home. *JAMA* 300: 834–835, 2008