Re: The Patient-Centered Medical Home Movement—Promise and Peril for Family Medicine

To the Editor: As a recent participant in TransforMed, I read the recent *Journal of the American Board of Family Medicine* article, "The Patient Centered Medical Home Movement—Promise and Peril for Family Medicine,"[1] with great interest. My thanks goes to the author, Dr John Rogers, for articulating so completely and with such deep insight what I came to realize after 2 intensely transformative years.

During that time my typical 1 doctor, 1 nurse practitioner private family practice office transformed itself into a 2.5 doctor, 1.25 nurse practitioner medical home complete with open access scheduling, an advanced electronic medical record (EMR), and a recently submitted application to the National Committee for Quality Assurance (NCQA) for a level 3 Physician Practice Connections – Patient Centered Medical Home certification.

I've addressed below in outline form those points which I found most compelling from your article and most consistent with my own beliefs about the patient-centered medical home (PCMH) concept and its future impact on restoring and reimbursing the value contributed to this country's health care system by its primary care physicians. Readers interested in reviewing the "Principals of the Patient-Centered Medical Home" can do so by going to www.aafp.org/online/en/home/policy.html.

1. "Care principals" and "Infrastructure principals" do not mutually insure each other. You are correct in your assertion that relationship-centered practices were like that from the beginning. I suspect practices that are already patient-centered will have a somewhat easier transition to the PCMH as they attempt to incorporate the "infrastructure principals" into their daily office routines.
2. Time, money, commitment, and superior leadership are necessary ingredients to survive the disharmony and change fatigue produced by the transformation experience. Try to imagine the strain on staff and physicians produced after months, not weeks, of the varied systematic changes operationally and technologically that are needed to go from a typical harried inefficient 20th-century primary care office poorly reimbursed on volume to the medical home practice of the 21st century whose reimbursements are based on the value of the documented quality of continuous coordinated care.
3. NCQA or some other independent objective organization will be necessary to distinguish a true medical home from those practices that want to take a shortcut and bypass the rigors required by the transformative process. Many family practices and perhaps certain other specialties will declare their practices to be medical homes. However, without a clear demonstration of in-place functioning systems and processes that verify the existence of the PCMH's fundamental principals, these declarations will be insufficient to qualify for the enhanced reimbursements designed to sustain this redesigned delivery of primary health care.
4. The financial rewards for attaining a medical home status must be substantial. A per member per month management stipend comprising the blended components required of a medical home which is then annually adjusted for inflation is a good start. The initial amounts announced by the Center for Medicare & Medicaid Services (CMS) and the commercial plans seem reasonable. However, incremental savings to CMS and the commercial plans must be transparent and shared fairly with the medical home offices that produced them. CMS, commercial plans, and medical homes must work together to closely monitor hospital and ER utilization rates and the resultant savings. This arbitrage must then be divided equitably. Confidence and trust must reemerge in the relationship between the providers of health care and those who pay for it. It is the only way to sustain the concept.
5. All certified medical homes should be exempt from preauthorization and precertification requirements. After all, evidence-based practices and clinical decision tools are integral parts of the PCMH which have already been shown to be cost-effective. This makes precertification and preauthorization unnecessary exercises and further reduces their burdensome administrative costs to patient care.
6. Lastly, the specialty must assiduously guard our ownership of the medical home. It was the centrality of the patient–doctor relationship and the coordination of continuing comprehensive medical care within the context of the family and community that defined our specialty in the first place and attracted so many of us decades ago. The basic tenets of family

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medicine when combined with the infrastructure principals described in your article become the medical home concept. So although the high-tech documentation of care may be new, the basic concept of the medical home is not.

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Reference

1. Rogers JC. The patient-centered medical home movement–promise and peril for family medicine. J Am Board Fam Med 2008;21:370–4.

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The above letter was referred to the author of the article in question, who offers the following reply.

Reponse: Re: The Patient-Centered Medical Home Movement – Promise and Peril for Family Medicine

To the Editor: I was pleased to read that Dr. Mambu's personal experience with transforming his practice into a patient-centered medical home validated points I made in the commentary. I also received positive comments from others who share similar perspectives.[1,2] I agree that the 6 points Dr. Mambu highlights are crucial considerations to guide refinement and implementation of the patient-centered medical home model of care and the recognition (accreditation if you will) and financing of practices. The emerging relationship among health care providers, insurance health plans, and health care purchasers is especially critical to the success of this innovation. I thank Dr. Mambu for his kind reply.

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References

1. Rittenhouse DR, Casalino LP, Gillies RR, Shortell SM, Lau G. Measuring the medical home infrastructure in large medical groups. Health Affairs 2008;27:1246–58.
2. 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 Affairs 2008;27:1219–30.

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Re: Outcomes From Treatment of Infertility With Natural Procreative Technology in an Irish General Practice

To the Editor: We read with interest the paper by Stanford et al[1] describing results from infertility treatment using a "systematic medical approach for optimizing physiologic conditions for conception." Although the authors make some good basic observations and their minimalist approach will no doubt appeal to many patients, extolling "Natural Procreative Technology" (NPT) as a general treatment philosophy for infertility is worrisome at several levels.

Considerable experience in subspecialty infertility practice has confirmed the age of the female is the single most important factor influencing a couple's reproductive outcome.[2] Early diagnosis and treatment is therefore critical to optimize success. But NPT's investigation phase alone requires 4 months to complete, and total deployment of NPT consumes 2 years. With their "biological clocks" ticking, it is not surprising that >50% of NPT patients dropped out.

Sadly, many probably never go back to their primary care provider. Patient satisfaction with the referring doctor is often related to timely referral to the fertility specialist. Some patients who conceive after in vitro fertilization (IVF), particularly if their primary physician failed to facilitate a prompt subspecialty referral, express deep resentment due to the patient's perception that their referral was needlessly slow.[3] This patient frustration has even triggered formal legal action seeking damages against doctors thought responsible for delayed infertility treatment.[4]

Studies of effectiveness of NPT against IVF in couples with unexplained infertility are welcomed. But curiously, Stanford et al assessed efficacy by cohort rather than the standard "per-cycle" pregnancy rate methodology, as followed by recognized registries in Europe and the United States. These patient registries have been collecting data on per-cycle pregnancy rates for many years. One reason they do not use longitudinal cohort analysis is because the further in time from intervention that a pregnancy occurs, the less likely that it actually resulted from treatment.[5] Although a cohort approach can have merit, its use by Stanford et al puts their conclusions outside the mainstream of relevant datasets and greatly diminishes the impact of their work.

It would be unfair to discount the potential usefulness of diagnostic tests collected during NPT. Cervical mucous monitoring, urinary luteinizing hormone surge testing, and reviewing timed intercourse schedules are all important patient education interventions and probably do help some women conceive. Yet the net effect of NPT seems closely allied to expectant management, reminiscent of a distant era where pregnancy rates rarely drifted above 25% per cycle.

The application of a structured infertility treatment program for use in general practice settings to improve care is not entirely new.[6] However, we strongly disagree with diverting 2 years of an infertility patient's time into a scheme where per-cycle pregnancy rates are unknown and where most patients, even when ideally selected, will quit treatment.

Providing comprehensive information to patients about treatment options is a cornerstone of the patient–physician relationship. NPT may warrant consideration

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