SPECIAL COMMUNICATION

Maximizing the Patient-Centered Medical Home (PCMH) by Choosing Words Wisely

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Background: **Culture is transmitted through language and reflects a group's values, yet much of the current language used to describe the new patient-centered medical home (PCMH) is a carryover from the traditional, physician-centric model of care. This language creates a subtle yet powerful force that can perpetuate the status quo, despite transformation efforts. This article describes new terminology that some innovative primary care practices are using to support the transformational culture of the PCMH.**

Methods: **Data come from the Agency for Healthcare Research and Quality–funded Working Conference for PCMH Innovation 2013, which convened 10 innovative practices and interdisciplinary content experts to discuss innovative practice redesign. Session and interview transcripts were analyzed using a grounded theory approach to identify patterns and explore their significance.**

Results: **Language innovations are used by 5 practices. Carefully selected terms facilitate creative reimagining of traditional roles and spaces through connotations that highlight practice goals. Participants felt that the language used was important for reinforcing substantive changes.**

Conclusions: **Reworking well-established vernacular requires openness to change. True transformation does not, however, occur through a simple relabeling of old concepts. New terminology must represent values to which practices genuinely aspire, although caution is advised when using language to support cultural and clinical change. (J Am Board Fam Med 2016;29:248–253.)**

Keywords: **Health Care Systems, Patient-Centered Care, Primary Health Care, Qualitative Research**

Recent changes in health care have produced a new lexicon that includes accountable care organizations, care teams, health care neighborhoods, value-based care, and shared care plans. Especially noteworthy is the recent articulation of the patient-centered medical home (PCMH), which is one of many indicators that the work of primary care is being reevaluated to better improve the health of people in a community.[1] The language used to describe clinical care processes and structures within the PCMH is important to consider—both for pragmatic concerns with branding and the more critical question of whether shifts in language can facilitate tangible improvements in patient care.

Language is a critical part of defining a culture.[2] Not only does the way we think influence the way we speak about ideas, but many scholars maintain that language also, importantly, shapes how we think.[3,4] According to Michel Foucault,[5] language

This article was externally peer reviewed.
Submitted 19 June 2015; revised 13 November 2015; accepted 23 November 2015.

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Funding: This project was supported by grant no. R13HS021287 from the Agency for Healthcare Research and Quality.
Conflict of interest: none declared.

Disclaimer: The content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality.

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creates the core organizing principles of power relations within institutions. Close attention to language can offer means for understanding the hierarchies, categories, and disciplinary practices that comprise social relations within institutions.[6,7] It is easy to see how the development of new language within the PCMH simultaneously conveys familiar concepts while also reshaping them to reflect a change in material relations that they signify.

Over the past three decades the social sciences have come to appreciate the role that language plays in shaping cultural perceptions and connections with policy.[8,9] How people categorize the objects and actions of their environments says much about their cultural values. Critical theorists of medicine, such as Sontag[10] and Patton,[11] have shown that the way we talk about illness impacts how we think about patients as well as how they experience disease. Patton, as well as Segal,[12] demonstrate not only that complicated rhetoric pervades the medical profession, but that greater attention to rhetorical strategies may play an important role in addressing lingering cultural challenges. What we have seen in critical theory is now mirrored in the changing language choices of innovative PCMH practices.

Much of the language used to describe the new PCMH is carried over from the traditional, physician-centric model of care.[13] In fact, the Patient Centered Primary Care Collaborative calls the PCMH a "physician directed medical practice."[14] This hierarchical reference is a subtle yet powerful force that can perpetuate the status quo and stifle change despite practices' efforts to transform, and it warrants reevaluation. Cultural change is not simply a matter of rebranding; however, incorporating new language may be an important first step in overcoming old habits and ingrained mental models.[15,16]

This article highlights new language currently used in some PCMHs. These terms exemplify how language can be adopted to facilitate practice transformation. After detailing new terminologies used in these 5 practices, we assess their institutional and systemic relevance, and consider some limitations to the use of new language to aid practice change.

Methods

Data for this article come from the Working Conference for PCMH Implementation in Denver, Colorado (March 2013), funded by the Agency for Healthcare Research and Quality. The 2½-day conference gathered representatives from 10 practices, along with an interdisciplinary group of content experts in the field of primary care, to intensely discuss implementation of 2 elements of the PCMH: (1) team-based care and (2) population management. Facilitators used a series of "inner circle/outer circle"[17] discussions and small breakout groups to encourage interaction and reflection around practices' experiences, successes, challenges, aspirations, and barriers to change.

Participant Selection

Potential participants were selected from a list of 150 primary care practices that was created for a project on workforce innovation in primary care funded by the Robert Wood Johnson Foundation. A review of the literature using 40 key terms to scan peer-reviewed material about workforce innovations in primary care in the United States since 2000 identified 331 relevant articles, from which investigators who had focused on workforce innovations were contacted and asked to nominate practices using a snowball sampling strategy.[18] Representatives from the practices on this list were interviewed in 2011 to 2012, and degree of innovation and sustainability in the practice was vetted by a team of researchers. From this list, we identified 19 practices with strong care teams and/or a population approach to care. After removing identifying information, our executive steering committee ranked these practices. The 10 highest-ranked practices were then invited to participate. One declined because of a lengthy system-level permission process to participate in the conference, so the next-ranked practice was invited. A representative from each practice attended the conference. The final group of participants represented 9 states and included 5 physicians, 1 registered nurse with a PhD, and 4 practice administrators. Practice settings included 4 family medicine (3 private, 1 owned by a health system), 1 pediatrics (private), 2 federally qualified health centers, 2 internal medicine (1 owned by a hospital, 1 by a system), and 1 nurse-led community clinic (co-owned by a university and a community). Other conference participants included 2 nationally recognized experts in each topic areas, 5 steering committee members, 4 dissemination consultants, 4 members of the research team (BFC, JH, KAH), and a

representative from the Agency for Healthcare Research and Quality.

Data

All conference sessions were audio-recorded, and typed notes were taken by multiple researchers, totaling 16 hours of recordings and 68 pages of notes. In addition, before the conference each practice participant wrote a 2- to 4-page summary of their practice's innovations and participated in a recorded 45- to 60-minute one-on-one interview at the conference venue with 1 of 3 qualitative researchers (JH, RSE, and a dissemination consultant). These were transcribed, totaling 164 pages.

Data Analysis

The multidisciplinary analysis team included 2 medical anthropologists, a family physician, an internist, a pediatrician, a political scientist, a sociologist, and a public health expert. Each analyst reviewed conference data and identified broad topic areas that emerged from this initial reading. "Use of innovative language" was an unexpected, but frequently communicated, topic of value for a number of conference participants. A subteam of 3 analysts (JH, KAH, BFC) divided conference data and did an intensive rereading, using an editing approach.[19] This team reviewed, identified, and extracted for analysis all uses of language innovation. They defined *language innovation* as the use of new linguistic terms to describe or infer new forms, functions, and cultural elements within the PCMH. The larger team was then engaged, through a series of conference calls, to refine the subteam's interpretations and develop a structure for the manuscript.

Practice participants were given the opportunity to review the manuscript, and there was enthusiastic agreement with our analysis from those whom we reached (4 of the 5). The study was reviewed and approved by the institutional review board at Rutgers University. Fictional practice names are used here to preserve anonymity.

Results

The use of new terminology for traditional practice roles and office spaces was evident in 5 practices. Our findings are structured around the innovative terms these practices used.

New Terminology for Team Roles

Greeter

The receptionist is traditionally considered an indispensable role in a medical practice, but there is no such role in Evolve Family Practice (EFP). Patients are met by a *greeter* who orients them to an electronic kiosk for self-check-in and offers refreshments while helping patients access the Web-based portal to update their health information. The intent is to create an enjoyable and meaningful first interaction in the office. The notion of a greeter evokes the value of personal connection rather than the traditional connotation of a registrar or phone operator. The shift from *receptionist* (who receives the patient) to *greeter* signifies a shift from a passive to active role, underscoring the proactive nature of the PCMH. It communicates to guests that they are the centerpiece of, rather than a mere "arrival" to, the visit.

Clinical Partner/Flow Master

The professional title of medical assistant (MA) has long been standard in the field. The practice referred to above, EFP, has taken the initiative to relabel the role as *clinical partner*. The term *assistant* reflects traditional hierarchical notions of limited roles in which tasks are clearly differentiated from clinician activities. Clinical partner suggests a shared governance in clinical tasks, with distinct but crucial and interdependent roles. It reflects a collaborative relationship based on a common mission to care for the patient. A physician explained that with this term, his practice is trying to dismantle the traditional chain of command because it does not fit with their motto: "Check your title at the door." He elaborated that the term acknowledges different strengths within the practice roles: "We [physicians] are very good at diagnosis, examination, and treatment plans. . . . We're not very good at managing our own time. . . . So we put our clinical partners in charge of our clinical day." The new term *clinical partner* empowers staff and serves as a reminder of the call for physicians to transcend physician-centric thinking and action.

At Harbor View Medical (HVM), the MA has been renamed *flow master*. HVM uses this term to reflect values and responsibilities that recognize the expertise of clinical staff in managing the flow of the clinical day. A physician explained: "Our MAs are [called] Flow Masters. . . . They are in charge; they are boss. 'You just tell me where to go and

when.' . . . They are experts in flow, and they should tell us [clinicians] at any point in the day what we should be doing."

Participant/Partner

Changing professional titles within the practice workforce to reflect person-centered, team-based values indicates a commitment to changing practice culture. It does not, however, re-imagine the role of those seeking health services. One practice, Spring Valley Clinic (SVC), uses the term *participant* instead of *patient*. Another practice, Highland Family Practice, uses the term *partner*. Traditionally, the term *patient* has problematically suggested someone to whom treatment is administered, evoking its roots in the Latin *pati*, meaning "to suffer." The terms *participant* and *partner* connote increased respect and mutual responsibility in health. A nurse practitioner at SVC suggested that people who come for medical care "want to be people," not patients. When the context is genuinely collaborative, the empowering language of participant or partner can allude to team membership—a core competency of the PCMH.

New Terminology for Clinical Space

Patient Lounge/Reception Area

The term *greeter* inspires a rethinking of the space in which this person works and offers an opportunity to redefine its use and its occupants' roles. A physician at EFP explained that their waiting room has been renamed the *patient lounge* to "reframe it as an interactive place" and a meaningful part of the patient's experience. The descriptor suggests a relaxing place where the anticipation, anxiety, and wastefulness of waiting is dispelled. Ideally, it becomes an introduction and extension of the type of interaction anticipated for the entire visit. To reinforce this, EFP made use of natural lighting, visual curves, carefully selected color schemes, live plants, and refreshments.

Another practice, Guardian Medical Associates (GMA), renamed its waiting room a *reception area*. Where the term *waiting* connotes a role defined by passivity, *reception* conveys a sense of receptivity and welcoming. Like the patient lounge at EFP, *reception area* helps to re-imagine the notion of a waiting room, but with different undertones, and emphasizes the transitory nature of the space through which patients move on their way to the examination room. The term reflects GMA's commitment to rooming patients within minutes of check-in. The lead physician insists that there is no need for a "waiting room" when patients are seen immediately.

Flow Station/Beehive

Corresponding to their role, *flow masters*' workspaces at HVM have been renamed *flow stations*. These spaces are designed to enhance flow by co-locating members of the care team for ease of verbal and nonverbal communication. The emphasis on the flow masters' responsibility reinforces this practice goal and signifies that flow masters oversee this station. Renaming workstations as flow stations helps to sensitize all team members to the importance of flow, serving as a reminder of ways they can facilitate the optimal movement of people and work tasks within the practice.

EFP renamed their clinical work area the *Beehive*. This term reflects the value EFP places on their team approach and conveys the sense of a collective workspace for industrious colleagues. The Beehive is located in the center of the clinical area, surrounded by examination rooms. Dividers are low so that line of sight is maintained across the space. Everyone on the care team works in this space during clinical sessions, making it easy to consult with one another. Consequently, most of the day's work can be completed during the clinical flow, rather than accumulating as "end of the day" tasks.

Discussion

While developing new terminology can aid practices in shedding obsolete conventions, genuine practice transformation does not happen through the simple relabeling of old concepts. Merely renaming roles and clinical spaces does not ensure that anything about the practice or care delivery fundamentally changes. Similarly, if patients end up with lengthy waits in lounges without interaction with greeters and other staff, they will be recognized as waiting rooms regardless of nomenclature. Worse yet, patients who sense terminological changes as empty gestures may actually have a worse view of practices if changes in language do not reflect changes in systems, structures, and behaviors. Cultural change is not simply a matter of rebranding. Practices must ensure that innovations in language are supported by substantive changes.

Using new language that emerges from an authentic vision of practice transformation can help to protect against one of the prevailing pitfalls of

transformation efforts: the checklist mentality. As practices strive to become PCMHs and achieve various certifications (e.g., National Committee for Quality Assurance and "meaningful use"), they risk falling into the trap of believing that fulfilling the requirements for these programs equals meaningful change.[20–22] The use of new language, when grounded in practice values and actions, can enhance awareness of those values and inspire creativity in expanding traditional roles and tasks.

Clearly, general resistance to change is one of the greatest hurdles to innovating medical practice language. Changes at EFP, for example, depend on clinical partners being seen by physicians as true partners. Partnership and team-based care require reworking traditional notions such as autonomy and systems of command and control.[16] However, many physicians are deeply invested in the very hierarchies that are reinforced by the language we have identified as being in need of change.[15] While research has noted that transformation to a PCMH "requires personal transformation of physicians,"[22] language within the PCMH often preserves traditional hierarchies. Primary care physicians are regularly referred to as "quarterbacks,"[23,24] "captains,"[25] and "hubs of all relevant care,"[26] each with connotations of authority and power.

One term that serves to minimize this hierarchy is *provider*. Commonly used as an alternative to *physician/doctor*, *provider* is problematic on another front: it links the service of health care with the business community's use of the title as a supplier of goods on the marketplace. This commodification of the profession may inadvertently serve the insurance industry's interests at the expense of the values of the medical profession and, ultimately, work against the goals of patient-centered, relationship-centered care. This example reminds us that we must take care in choosing the metaphors and names through which we understand the various roles within the PCMH and in the health care neighborhood more generally.

One limitation of this study is that we do not know what actually transpired in these 5 practices. For example, we do not know how these language changes were implemented and received, or whether they were effective. We only have access to what the conference representatives reported. While some participants' preconference summaries were collaboratively written and/or vetted by other members of their practice, this was not the case for all. We also do not have a perspective from patients about how they perceive the language changes in these practices. Important insights would undoubtedly come from a study design involving extensive onsite practice observation and interviews with practice members and patients.

An additional limitation of this study was that since the theme of new terminology was identified only through data analysis after the conference, we were unable to officially explore the topic in depth with participants. Consequently, we are unable to describe the process by which language changes facilitated practice transformation, as the data do not allow for that level of analysis. It is also possible that other participating practices, in addition to the 5 highlighted here, made use of new language, but since we did not identify it as a theme until after the conference, we did not explicitly ask about it. That the theme of language innovations emerged among these 5 practices suggests that this may be an important element of practice transformation. Future research could help us understand how the intentional use of new terms assists in the practice culture transformation process.

Conclusion

Research is increasingly showing that the development of a PCMH requires fundamental practice transformation, not simply the addition of new tasks or workflow changes.[21,27,28] Such transformation relies, in part, on the shifting of mental models and the creative reimagining of practice roles.[15,29,30] Our data suggest that these innovative practices recognize that developing new terminology around those roles can facilitate and deepen that process. At the same time, we must guard against quick or trivial fixes. It is important to critically reflect on the language choices we make to understand not only how language shapes culture and interacts with relations of power but also the dangers of reducing practice transformation to a thin branding campaign. Such reflection might also protect us from perpetuating the often subtle cultural messages embedded in our words that we do not wish to reinforce. Thinking through these messages and reworking entrenched vernaculars requires an openness to change, an ability to distinguish symbolic change from real change, and a willingness to change course even when exciting new vernaculars turn out to create new problems. If these caveats are heeded, the creation of genuinely

innovative language may be a critical part of the work of primary care transformation.

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