Primary Care, Specialist Care, and Chronic Care

Can They Interlock?

In this issue of CHEST (see page 200), Kirschner and Barr present the concept of the Patient-Centered Medical Home (PCMH) in the context of the opportunities it presents to specialists to contribute to advances in the organization and delivery of health services in the United States. It is only recently that the challenge of coordination of care when patients move from inpatient to outpatient and from doctor to doctor has been appreciated. The challenge is considerable: in the United States, most patients see both primary care physicians and specialists in any given period of time. For example, a recent study showed that 64% and 95% of the elderly see a generalist or a specialist, respectively, in a year, with an average of almost nine visits to specialists and four different specialists seen. The corresponding figures for the nonelderly (including children as well as adults) are 81% and 69% for seeing one or more primary care doctors or specialists, respectively, and 1.3 and 3.3 different primary care physicians and specialists, respectively, seen in a year. Almost half of all visits to specialists are for routine follow-up initiated by the specialist. In view of the very high use of specialist services in the United States (compared with other Organisation for Economic Cooperation and Development [OECD] countries), any proposals to revamp primary care must consider the role specialists play in ongoing (as well as consultative) care of patients.

After describing the proposals for the medical home and indicating “widespread interest and advocacy” for it, Kirschner and Barr suggest three requirements for specialists to be recognized as medical homes: provides primary care or principal care (the latter differing from primary care in its specialty focus but also “meeting most of the patient’s healthcare needs”), has a practice structure to provide care consistent with the medical home model, and is willing to provide care consistent with the joint (primary care) principles of the medical home. As most specialists are unlikely to take on the obligations of a medical home (first-contact accessibility, meeting most of their patient’s health-care needs, providing a comprehensive range of services for different needs, and coordinating care), an alternative, the PCMH “neighbor” is available.

Being a PCMH neighbor requires working together with the PCMH to enhance coordination of care and improve consultations and comanagement to create “seamless transitions” for patients. Such a model might be most appropriate when the patient has a condition that is rare (and therefore not one that a primary care physician can maintain competence in dealing with it), or when the patient has an acute but time-limited and unusual exacerbation of a chronic condition (eg, chemotherapy for a malignant condition, the first year after an organ transplant, the few months following a traumatic brain injury), in which instances the primary care physician would act as consultant to the specialist. International experiences with such special situations are not cataloged; it would be worthwhile to do so, particularly by studying countries with a strong primary care infrastructure.

Before there can be any progress in designing the operational form of the PCMH and its neighbors, two issues require resolution.

1. The primary care functions of the PCMH must be made operational. The basis for the concept of the PCMH derives from the robust evidence of the benefits of primary care. However, the elements that are proposed for use in “recognizing” a PCMH, which were heavily based on an instrument to assess elements of the chronic care model, do not adequately fulfill the criteria for primary care functions. Primary care functions require a mechanism for identifying
an enrolled population of patients and for the facility to serve as the ongoing source of care for that population over time, regardless of the types of problems experienced by patients. (That is, care must be person focused rather than disease or procedure focused.) It requires that care be comprehensive in dealing with all of the health problems that arise in its population, except those that are too uncommon to be dealt with competently, and for care to be coordinated when patients have to be referred elsewhere in those situations. The proposed recognition mechanism for the PCMH relies heavily on structural elements of electronic health records, computerized guidelines, and ill-defined teams of personnel rather than having to demonstrate adequate provision of primary care, despite the fact that there are existing instruments to do so. Its assessment of illness care is limited to a small subset of specific chronic illnesses—a situation that makes it incompatible with comprehensive care, either as measured by a broad range of services available if needed or a broad range of services provided to its population. If there is no assurance that a PCMH is actually providing high-level primary care, there is no way for a specialty service to demonstrate that it is doing so.

2. Specialty societies must develop a set of principles and functions that characterize specialty care, similar to what has been accomplished for primary care over the past 20 years. Forrest noted that specialists are trained to focus on particular diseases or types of interventions and classified their role into five categories: cognitive consultant, procedural consultant, comanager with shared care, comanager with principal care, and primary care. Their role in the one-half of all visits for routine follow-up needs clarification because it may be more appropriate for this to be done by, or at least coordinated with, primary care physicians. Clues regarding the appropriate roles of specialists might be sought in international comparisons. Referral rates to specialists are higher in the United States, where medical advisors are paid by salary. In countries where they work in community settings (such as Germany), payment for their services (as for primary care services) is heavily regulated by insurance companies, in contrast to the situation in the United States, where medical advisors working for individual insurance companies decide whether they will approve or disapprove payment for services rendered by primary care physicians vs specialists. As these advisors are often subspecialists, it is not uncommon for them to decide that certain procedures, although common in the population, will be reimbursed only if provided by specialists.

Complicating decisions about the relationships between primary care physicians and other specialist physicians is the focus on the chronic care model. While not incompatible in principle with primary care (which is patient-focused care over time and hence “chronic”), the implementation of the chronic care model has been entirely with specific chronic diseases such as diabetes, asthma, and heart disease. In fact, the origins of the “medical home” arose in the context of children with chronic illness. Orientation toward specific diseases in the medical home threatens the basic principle of primary care, which focuses on the totality of health-related experiences of patients and populations. When practitioners are focused on diseases and their management, they focus less on the spectrum of problems that people face in dealing with their overall health problems in daily life. The ability to focus on patient-defined (rather than professionally defined) health problems accounts for the benefits that accrue to patient health, population health, and equity in health within and across populations. Contributing to improving primary care, finding a better way to characterize and deliver specialty care, and devising mechanisms to make primary care/specialist interactions pursuant to improving health and equity in health will be an important challenge for health professionals in this country.

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**Is There Room for Specialists in the Patient-Centered Medical Home?**

The Patient-Centered Medical Home (PCMH) is one of the new ideas being proposed as a transformative health system innovation. More than 30 states are testing medical homes in Medicaid and State Children’s Health Insurance Programs, which is sensible given the medical home’s long-standing use by some pediatrics practices. But medical homes are also now being broadly tested in practices serving adults; more than 20 multistakeholder demonstration projects are underway in 14 states, and the Centers for Medicare and Medicaid Services are prepared to initiate PCMH demonstrations in 400 practices in eight sites, pending possible expansion of the demonstration as a result of health-care reform legislation.

In broad terms, a medical home is a physician-directed practice that provides care that is “accessible, continuous, comprehensive and coordinated and delivered in the context of family and community.”

And despite ongoing differences in opinion as to what the primary attributes of a medical home should be, there is hope that primary care practices, serving as medical homes, can provide a source of confidence, advocacy, and coordination for patients as they encounter the increasingly disconnected parts and daunting complexity of the health-care system.

The article by Kirschner and Barr in this issue of *CHEST* (see page 200) brings the prospective roles of specialists and subspecialists into the medical home discussion. Until now, the PCMH has focused on primary care physician practices, raising reasonable concerns from specialists about whether they have been left out of the discussion; it has long been recognized that specialists are often the “principal” physicians for patients with chronic conditions, such as COPD and asthma. Indeed, as noted by Kirschner and Barr, some internal medicine subspecialists, such as pulmonologists and endocrinologists, might be well positioned to qualify their practices as medical homes because of their ongoing roles as principal physicians, that is, by providing first-line care for a patient’s complex care needs associated with a chronic condition while also meeting that patient’s general health-care needs.

For their part, primary care physicians have raised concerns that they will be held accountable for the activities of the specialists concurrently providing care for their patients, particularly the activities related to patient-centered aspects of care, a core component of the PCMH concept. Specifically, primary care physicians often complain that patients call them to try to gain an explanation of the information given to them by the hard-to-access specialists they have seen. In calling for a “medical neighborhood” to house the medical home, Fisher has pointed out that there are no current incentives for other physicians or hospitals to share information, improve coordination, or support shared decision making for patients who are in the medical home.

Considerations regarding how to deploy the medical home raise fundamental questions about the relationship between primary care physicians and specialists in providing care to patients who have one, or increasingly, multiple, serious chronic conditions. In a recent, insightful editorial in the *Annals of Family Medicine,* Strange and Ferrer identified the paradox of primary care. They write, “The paradox is that compared with specialty care or systems dominated by specialty care, primary care is associated with the following: (1) apparently poorer quality of care for individual diseases, yet (2) similar functional health status at lower cost for people with chronic disease, and (3) better quality, better health, greater equity, and lower cost for whole people and populations.”

They suggest that the paradox can be understood by evaluating care not only at the level of specific illnesses but also in the context of the whole person, communities, and populations, with the whole person and community foci currently undervalued. They attempt to resolve the paradox by asserting that systems of care are needed that value both generalist and specialist care and that foster integration. In short, care needs to be shared, or comanaged, between primary care physicians and specialists, yet that aspect of the medical home has received little attention.