■ **COMMENTARY**

The Patient-Centered Medical Home as a Community-based Strategy

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ABSTRACT

Increasing attention has been devoted to the important role that primary care will play in improving population health. One innovation, the patient-centered medical home (PCMH), aims to unite a variety of professionals with patients in the prevention and treatment of illness. Although patient perspectives are critical to this model, this article questions whether the PCMH in practice is truly community-based. That is, do physicians, planners, and other health care professionals take seriously the value of integrating local knowledge into medical care? The argument presented is that community-based philosophy contains a foundational principle that the perspectives of health care practitioners and community members must be integrated. Although many proponents of the PCMH aim to offer patient-centered and sustainable health care, focusing on this philosophical shift will ensure that services are organized by communities in collaboration with health care professionals.

INTRODUCTION

The American health care system is in trouble on at least two levels. Care is too costly and is unevenly distributed. As a result, many disparities exist. The patient-centered medical home (PCMH) is proposed as a remedy for this situation. According to the National Committee for Quality Assurance, which provides official PCMH recognition for practices through care coordination, "Patient-centered medical homes transform primary care practices into what patients want: health care that focuses on them and their needs."[1] The fundamental premise is that this model will allow care to be accessible and offered in a sensitive and effective manner. Money will thus be saved and care improved.

In this regard, some critics argue that the PCMH represents "enhanced primary health care."[2] In fact, the conference held in Alma-Ata, USSR (now Almaty, Kazakhstan), in 1978, has been identified as the proper context for this movement. The assumption that guided this meeting was that health care had to be improved for the masses.[3] Morally and socially, the health disparities that existed around the world should no longer be tolerated.

The philosophical change that was generally endorsed elevated the role of communities in delivering adequate care. With care tied closely to these groups, relevant services could be provided in a timely manner. Along with community involvement, prevention and education should be emphasized. In this way, a range of care would be integrated into local settings, so that health promotion was normalized and made a vital part of everyday life.

In many ways, the PCMH represents this sort of coordinated care. The goal is to meet a variety of needs in a holistic manner, within the framework of the family and community.[4] The emphasis is on care coordination and continuity so that health decisions are made jointly by clinicians, patients, and others deemed to be relevant to treatment. This ongoing process of communication is thought to minimize gaps in care and to promote widespread access to services that are necessary for each patient. This kind of care environment is thought to lead to favorable health outcomes.

The problem is that the PCMH in theory or in practice is not necessarily community-based.[a] For example, in Ohio some practices transitioning to PCMHs have attempted to center care around patients by gathering data on patient satisfaction through the use of surveys, focus groups, or patient advisory boards.[5] These strategies allow patients to weigh in on existing practices but do not instigate a truly collaborative model of care. Although the language of patient-centeredness is at the core of the PCMH, this does not necessarily ensure that authentic practice changes will follow that are community-based in nature.

Perhaps advocates of this model did not appreciate the radical nature of public health care? Nonetheless, many patients are not comfortable with the PCMH, and critics have questioned whether this model is suited to address the social determinants of health and inform health policy.[6,7] To correct these shortcomings and to integrate patients effectively into care, health care leaders may enhance the PCMH with a dose of community-based philosophy. After all, patients and their communities must be fully engaged if interventions are going to be perceived as valid and if this model is to be truly effective.

Yet, becoming community-based is not as simple as making contact with a few prominent members of a community or locating a clinic in a neighborhood. In fact, identifying a community is difficult. As will be discussed in the section Becoming Patient-Centered, communities are certainly real but are somewhat elusive, and thus gaining entrée to these groups and gaining their trust takes time and a lot of effort.[8] What is needed to achieve this aim, in addition to a proper philosophy, is a long-term vision of health care and a clear understanding of the role a community must play in the process of delivering these services.

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BECOMING PATIENT-CENTERED

Many critics today argue that the current health care system is unworkable.[9,10]

To the detriment of the public, the promise of PCMH has not been realized, and treatment has drifted away from communities. Primary health care is thus again en vogue, particularly the notion that local persons should play a central role in the design of interventions. For health care leaders to make care relevant and sustainable, and thereby reduce costs, the health system must be revamped from the ground up. Especially important is that attention be directed to the cultural side of medicine.[11]

Although competing definitions of primary care exist, some common elements are present.[12] Particularly noteworthy is that care is coordinated. An integrated system is created with a single point of entry with uniform, sequential steps of treatment and referral. Perhaps most important is the focus of this system: The community. In this sense, public health care is patient-centered.[13] The values, beliefs, and commitments of these persons should guide the development, implementation, and evaluation of any social intervention.

The assumption is that communities are not simply places or associated with a collection of demographic traits. Communities constitute worlds—specifically moral worlds, as Kleinman[14] says—that outline a range of norms, including those related to health and illness. These rules, furthermore, reflect the definitions and decisions these persons treat as central to maintaining their community.

Communities are not necessarily identified with objective referents. Persons weave stories about themselves, their relationships, histories, and other facets of their lives.[15] These narratives, accordingly, provide insight into the multiple perspectives that are present, along with how these outlooks sometimes overlap. Different portrayals may exist, for example, about the boundaries of a community or the most accessible location of a clinic. In this regard, a community constitutes a montage of worlds created by the story lines that members understand and should be the focus of interventions.

Allowing communities to control health projects makes sense only within this framework. Illness is predicated on the experiences and the community story lines that are operative.[16] Accordingly, the relevance and success of interventions depends on the local stories, and related explanations, about sickness and cure. This change in strategies, however, is not merely a philosophical concern and should not be perceived as a burden to medical practitioners. After all, community engagement is touted to be essential for appropriate interventions.[17] Furthermore, improved health care should serve to reinforce the effort needed to truly engage individuals and communities.

Gaining entrée to the world of a community is vital to the success of primary care. In some circles, emotional intelligence is considered to be part of this process.[18] Because of the need to enter the world of a community, emphasis has been placed on developing interpersonal skills, such as empathy and emotional management. The point is that through these activities interpersonal connections can be made that are informative and supportive.

With these skills, health planners can develop the partnerships necessary to engage communities. A community's needs, perceptions, and expectations, along with dignity and respect, can become the focus of attention. Additionally, a corollary of this participation is that communities can become more self-reliant and healthy places to reside. Communities can acquire the skills necessary to monitor themselves, construct interventions, and formulate effective health policies.[19]

However, some of these aims have not been realized. Many health projects have made connections with communities, but entering their worlds has been a different issue altogether. For example, many patient or community advisory boards exist to solicit opinions from community members, but there is little room for authentic collaboration.[20] In these cases, planners and practitioners have been sensitive and compassionate without necessarily giving a community control of a clinic or project.[21] Consultations, in this sense, are insufficient to achieve community entrée.

However, without placing a community's world at the center of an intervention, how can these projects be relevant? These assumptions, definitions, and actions are crucial to the correct understanding of health behavior. Real public health care requires a close reading of the historical context and current preferences of a community if interventions are going to be effective.

Becoming patient-centered must extend beyond a concern for the well-being of patients and a sensitivity to their interests or fears. In public health care after the Declaration of Alma-Ata, a larger issue must be addressed:[3] How can local knowledge begin to guide health care? The success of this maneuver depends on a philosophical shift that will be raised later in the section A Community-based Additive. At this juncture, however, the important point is that communities are not objects but are actively created by their members. Here again, the issue of a community's world arises.

PATIENT-CENTERED MEDICAL HOME

A relatively new health care model, rooted in primary care, is receiving some attention nowadays.[22] This strategy appeared initially in 1967 to provide holistic and dependable care to the chronically ill.[23] The name *patient-centered medical home* has been adopted by this approach to providing health care.

Although facilities are a part of this health project, the PCMH constitutes a model rather than a specific institution. The metaphor of "home," however, is telling. The aim is to offer accessible, comprehensive, continuous, and coordinated care.[24] Consistent with the notion of home, patients are supposed to be treated in a sensitive and supportive environment, with emphasis placed on their values and preferences.

At the core of the PCMH is the goal of transforming medicine to meet the needs of individuals and communities. In this regard, a "whole person" orientation is adopted. Rather than a bundle of organs, persons are understood to be socially situated and expressive. Any adequate intervention, accordingly, requires that they be actively engaged and directly involved in the treatment process.

Patients, family members, and caregivers are at the center of every medical decision.[25] Therefore, coherent and lasting

partnerships should be fostered with these persons. Decision making should reflect the daily practices of patients, thereby including interpersonal contacts and local health networks. Patients and their communities, in short, are presumed to be interconnected.

Clearly, patients are not passive in this process. Medical information should be shared, in addition to emphasizing the importance of relationships in healing. Transparency and sensitivity are the watchwords of the PCMH. Indeed, these traits are thought to lead to better health outcomes and a higher degree of patient satisfaction.

Yet, the question remains whether the PCMH is really community-based. Focusing on treatment goals and options, monitoring, information dissemination, and support, for example, does not necessarily mean that individuals or communities are in charge of interventions. In this regard, some research has found that the physicians involved with the PCMH are aloof, distant, self-absorbed, and too focused on medical technology, such as their computers.[6]

Apparently patients are consulted but often are not quite the centerpiece of this medical model. Although the rhetoric is appealing, the real interpersonal connections that are essential for the PCMH to succeed are missing. In the absence of patient control, dignity and respect can easily fall by the wayside.

The result is that the PCMH has been characterized by patients as too formulaic and heavy on bureaucratic control.[6] In fact, medical technology is often relied on to provide a seamless network of care, rather than interpersonal dialogue or community entrée. To become community-based and avoid these negative outcomes, a PCMH must address several philosophical issues that have not been emphasized by the PCMH. These themes illustrate the importance of individual and community control in formulating a health intervention.

A COMMUNITY-BASED ADDITIVE

In theory, the PCMH seems to be committed to patients participating in their care, but in practice this activity is often lacking. The participation that does exist is limited to consultations, although partnership is desired.

Consultations may be sufficient to exhibit interest in patients, and perhaps supply some emotional support, but becoming community-based is far more complicated.[26] Specifically noteworthy is that this outlook is based on a philosophical maneuver that is not an integral part of the current discussion about the PCMH. However, according to some critics, a health project will not likely become community-based in the absence of this shift in thinking.[19]

At the core of this community-based philosophy is an epistemology that leads to authentic participation by individuals and communities. Persons are understood to shape their realities through their actions and communication.[27] Through the use of language, for example, persons and communities weave stories about themselves that give meaning and continuity to their lives.

Social reality is thus not something encountered but constructed.[28] Persons define, select, and commit to certain interpretations of behavior and events, thereby giving these phenomena significance. Health and illness also are enmeshed

in this process. How these medical considerations are conceptualized, and thus dealt with in practical terms, may differ greatly between communities.

Those who are committed to a community-based philosophy reject the dualism that supports mainstream thinking about medicine.[29] According to the dualist paradigm, facts are objective, whereas definitions and commitments are subjective and treated as ancillary to these data. A community-based health strategy, on the other hand, does not make this distinction and marginalize the daily experiences of persons and communities. For this reason, personal and collective beliefs and other sentiments are thought to shape how people respond to health and illness, and thus should not be downplayed or overlooked.

Local knowledge, therefore, directs all community-based interventions.[21] Personal and collective control are paramount to a community-based project. What this term means in this context is that local definitions, conceptual schemes, history, and related cultural themes are central to adequately identifying illness and all remedies. Local knowledge is not optional in the design, implementation, and evaluation of a project and entertained, if available, but key to a successful intervention.

Community members are invited to participate in the construction of any instruments that may be used to accrue data or make clinical assessments. Community-based projects have used local health workers or health committees that function in this capacity.[30,31] In these examples, local residents are trained to participate fully in research or clinical care. Health committees, which are often composed of both community health workers and other community members, can develop research projects to assess illness in an area and discuss interventions that are compatible with local values. For example, a health committee in the Southeastern US developed research instruments to understand human immunodeficiency virus (HIV) stigma in a community, and through a collaborative research process informed local HIV clinical trials and educated practitioners on the services needed by local residents.[32] Most important is that in community-based projects, persons are not merely consulted but play a key role in and basically control any intervention.

In the context of primary care, a recent project on the island of Grenada aimed to engage local residents in developing a local health needs assessment that would be used to inform the development of local services and as a basis for making referrals for specialty care.[33] A health committee was formed of neighborhood residents, and they worked collaboratively to develop an assessment that would screen for health conditions that were relevant in this community and would improve communication between physicians and patients. The outcome of this process was that residents felt integral to primary health care in this area.

Because persons and communities create worlds through their actions, entrée must be gained to those domains, or we risk never properly understanding illness-related behavior. The aim of a community-based initiative, accordingly, is not simply to amass data about the objective features of an individual or collective, but rather to become correctly attuned to the interpretive and inventive process that creates the meanings treated as factual. Any method used, therefore, should not focus on the collection

of data but on how the meanings of health and illness have been socially constructed through personal and interpersonal actions.

The principle that is operative at this juncture of community-based work is dialogue.[34] Although this idea is a regular part of discussions of community-based strategies, dialogue is often trivialized by health practitioners. Often dialogue is equated with exchange, awareness, companionship, or helping.[35,36] In each of these cases, persons or communities may be encountered, but a genuine relationship is not necessarily established.

Dialogue requires that persons confirm one another. The world advanced by a person or community must be grasped, although in a particular way. Specifically, others must be understood in their own terms. Persons enter the experience of others and treat this knowledge as real, even if this realm defies normal expectations. The thrust of dialogue, accordingly, is to overcome preconceptions about normalcy or illness and to understand the perspectives held by others on these or related issues. In this regard, real dialogue involves discovery.[37]

Clearly, dialogue is related to trust, but in a strange way. Dialogue cannot occur without trust, although trust is supposed to be enhanced by this process. In the end, however, trust is not a matter of contact, decorum, or emotional connection, but related to world entry.[38] Individuals must make themselves vulnerable enough to let others into their worlds while becoming more confident in this activity as interaction proceeds. As trust becomes more stable, practitioners and community members can begin to collaborate more fully in designing health services.

Niklas Luhmann, a seminal writer on this issue, made a distinction that is important between trust and familiarity.[39] His point was that becoming familiar with persons is not the same as, and does not necessarily lead to, trust. Regarding becoming community-based, the idea is that simply hanging around a community or making intermittent contact is insufficient to establish trust. Trust instead requires that solidarity be established; practitioners and community members must treat one another seriously, and over time the prospect for world entry and, thus, true collaboration improves.

In the absence of dualism, the world of others is not off limits. For this reason, local knowledge is accessible if persons take the time to reflect on their preconceptions and address what others intend. In this way, the PCMH can become community-based and realize the partnerships that are touted as basic to effective health care. A certain philosophical gambit, however, is required to achieve this end.

CONCLUSION

Home is an appropriate term to characterize the care promoted by the PCMH. Connotations such as comfort, connection, and support reveal the aim of this health strategy: To provide pertinent and comprehensive services in an inviting manner. Care should be offered in a commodious realm.

Home is a metaphor rather than a specific institution. Nonetheless, in a community-based project, home does have a location. Home, created by persons and communities, represents the domain or world where their values, definitions, and commitments are normative. When provided in the context of this home, care should be appealing and likely accepted. Sustainability, in fact, depends on this appeal.

For the aims of the PCMH to be realized, one must seriously reflect on the theme of home. The aim of this article is to link this idea to the world created by the interpretive actions undertaken by persons and communities. As a result, the improvements in health care that are associated with the PCMH might come to fruition. The desire to become community-based might be more than an ideal.

Like any home, however, outsiders must be invited to enter. Clinicians, accordingly, do not gain entry by simply showing up, but through dialogue that opens the doors to a person's or community's world. From this vantage point, care is not a service or an exchange, but an invitation to listen, to help, and to mentor. Surely, in this manner, medical treatment can become dignified, respectful, and effective, as proponents of the PCMH desire. ❖

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a Although an analysis of the criteria for a PCMH is beyond the scope of this article, there is certainly an opening for requiring the implementation of community-based strategies into a practice. For example, local health committees could develop sustainable practice interventions to engage patients, evaluate patient care, and conduct research on health outcomes.

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Personal

The treatment of a disease may be entirely impersonal;
the care of a patient must be completely personal.

— Francis Weld Peabody, MD, 1881-1927, American physician and professor at Harvard Medical School