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ANALYSIS & COMMENTARY

Small Primary Care Practices Face Four Hurdles—Including A Physician-Centric Mind-Set—In Becoming Medical Homes

ABSTRACT Transforming small independent practices to patient-centered medical homes is widely believed to be a critical step in reforming the US health care system. Our team has conducted research on improving primary care practices for more than fifteen years. We have found four characteristics of small primary care practices that seriously inhibit their ability to make the transformation to this new care model. We found that small practices were extremely physician-centric, lacked meaningful communication among physicians, were dominated by authoritarian leadership behavior, and were underserved by midlevel clinicians who had been cast into unimaginative roles. Our analysis suggests that in addition to payment reform, a shift in the mind-set of primary care physicians is needed. Unless primary care physicians can adopt new mental models and think in new ways about themselves and their practices, it will be very difficult for them and their practices to create innovative care teams, become learning organizations, and act as good citizens within the health care neighborhood.

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There is widespread agreement that a reformed health care system will require a substantially redesigned primary care infrastructure. Innovative practice models, such as the patient-centered medical home, have captured the imagination and hope of a wide spectrum of health care reform and primary care stakeholders.[1–6] Often payment reform is seen as a major strategy for facilitating implementation of new practice models. Our team has researched improvements in primary care practices for more than fifteen years and has intensely studied more than 400 small primary care practices using in-depth qualitative and quantitative approaches.[7–10]

Working with small, autonomous practices—where most Americans receive care[11]—has allowed us to observe a set of characteristics found in many small primary care practices that are substantially unlike those in large integrated systems or federally qualified health centers. These common characteristics are likely to inhibit transformation to innovative practice models even in the presence of considerable payment reform. Although we have studied a variety of strategies for practice change, we have been impressed with how universal and deeply embedded this small set of characteristics is. Most of these characteristics are so ingrained in the primary care practice culture that they have become virtually invisible, along with their implications.

This article examines four characteristics and two associated themes of the culture of small primary care practices, all of which act as bar-

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riers to transformation to a patient-centered medical home. We describe three principles that will be required to achieve new models of primary care delivery but that will be difficult to incorporate into the current culture of small primary care practices.

Four Ingrained Characteristics

PHYSICIAN CENTRICITY Small primary care practices are generally very physician-centric. This may seem reasonable since physicians are often owners or major financial stakeholders of the practice, hold most of the clinical knowledge, and are the revenue engines of the practice. However, practices that revolve primarily around physicians' schedules, approaches to practice, and preferences for use of office systems find it difficult to innovate to maximize patient-centered care.

Physician centricity also manifests itself in the organization and internal dynamics of the practice, such as communication patterns, power behaviors, and trust, as well as practice personnel's feeling psychologically safe to express themselves. As a result, most practice-level decisions are made with little input from those who see the patient experience from other perspectives. Tradition, reinforced by training, has deeply ingrained physician centricity in current practice models. Although it may be a more recent contributor, we cannot explain physician centricity as simply a learned response to current reimbursement policy.

LACK OF COMMON VISION, COMMUNICATION, AND SHARED EXPERIENCE AMONG PHYSICIANS Physicians' practice styles vary widely. However, most physicians value an autonomous practice, where they neither look over their colleagues' shoulders nor expect others to scrutinize their work. Primary care physicians communicate about practice operations, such as new guidelines, changes in formulary, and administrative issues. Yet they rarely engage in meaningful communication about overall practice vision, approaches to patient care, clinical priorities, and individual strengths and weaknesses. For example, a physician rarely can describe a partner's approach to depression care or behavioral change except in general terms.

AUTHORITATIVE LEADERSHIP BEHAVIOR LEADING TO LACK OF PSYCHOLOGICAL SAFETY Practice staff members such as nurses, medical assistants, and receptionists see physicians as powerful leaders because of their extensive training, clinical knowledge, and time-honored societal role. We have observed many behaviors, usually unintended, that reinforce the power differential between physicians and others working in the practice. These include lack of attention to staff turnover, exclusion of staff from clinical discussions, and failure to consider staff input in decisions about office procedures. These physician behaviors lead staff members to be reluctant to contribute to discussions proposing practice change or to challenge physicians in such discussions. This staff reluctance is present even when the physicians themselves espouse a more participatory practice.

VARIED BUT UNIMAGINATIVE ROLES OF MIDLEVEL CLINICIANS Many small primary care practices include one or more midlevel clinicians, such as nurse practitioners or physician assistants, often employed to enhance practice revenue. Often they have their own panel of patients with occasional emphasis on either chronic or acute care. Midlevel clinicians often do nearly the same work as physicians, although clearly remaining at a lower level of the clinical hierarchy. We rarely observed midlevel clinicians' being engaged by the practice to perform activities that provided a value-added service, such as care coordination, behavioral health, mental health, family life, or dietary counseling, as they often do in large integrated systems.

The Tyranny Of The Small Primary Care Practice Culture

DUAL STRUCTURE These four characteristics interact to create a dual structure:[12] a loose federation of clinicians, who emphasize autonomy and independence, and an organization of support staff, whose major purpose is to maintain patient flow and relieve the physician of less complex tasks. The clinicians' practice philosophies often vary in fundamental ways that are seldom recognized or discussed. Support staff members are generally limited to tasks such as creating patient schedules; triaging phone calls; managing ancillary information, such as laboratory and consultation results; and responding to patients' telephone requests.

THE PRIMACY OF PATIENT FLOW Patient flow and physician efficiency, often expressed as "cycle time," are major guiding principles for defining work and practice redesign, and they are driven largely by fee-for-service reimbursement pressure. We observed many practices with near-assembly-line precision in processing patients for efficiency of the time they have with the physician. Staff in these practices are often encouraged to anticipate physicians' needs and stay "an examining room ahead" of the physician. The primacy of the need to maintain patient flow to enhance cycle time causes many practices to think they are managing patient health, when in fact they are managing patient flow. A sensible

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payment reform that rewards quality of care over volume of care may reduce some of the pressure on cycle-time thinking.

Rethinking Primary Care Practice

Redesigning primary care practice turns out to be more difficult than many imagined, with the realization that transformation requires more than just checking off boxes or implementing technical components.[13] We believe it will be even more difficult for small primary care practices to make the necessary transformation because the physician characteristics we have described are so deeply ingrained in their mental models and organizational culture. Although many small practices have been purchased by hospital systems and in theory should be reenvisioning themselves as parts of larger systems, we also have observed that these characteristics are so embedded in the practices that their mental models will not change in the absence of specific efforts to do so.

The relationship-centered vision of primary care, in which the nature and quality of relationships are central to health care, will continue to be crucial.[14] But traditional mental models of primary care physicians also must embrace a broader vision of meeting the expanded set of needs that define contemporary primary care in which the majority of visits are for patients with complex conditions or needs, or both. Many patients in contemporary primary care practices have multiple chronic illnesses or mental health needs—not simple acute conditions or single chronic conditions—or are cancer survivors. We have observed that changing mental models within a practice is particularly difficult for the physicians—for example, shifting a physician-centric vision of primary care to one that values the collaborative care teams needed for the new realities of primary care practice.[15]

Both meeting the needs of patients and the expectations of society and promoting primary care as a foundation of a reformed health care system require that physician practices move beyond doing the same things better to continually envisioning better things to do. In our work we have seen instances in which practices were able to make creative changes. When we examined these practices more closely, we generally saw that they were working as an entire practice, were learning as a group, and were actively interacting with their local health care environment. Based in part on these observations, we summarize three principles that are essential for new designs for primary care practice to emerge.

THE TASK OF PRIMARY CARE REQUIRES AN ENTIRE PRACTICE The task of primary care has become much more complicated since its reemergence in the United States in the 1960s, when the majority of patient visits were for relatively simple acute conditions or single chronic conditions, the number of pharmaceutical options were limited, and most cancer patients had limited life expectancies. Expectations now include comprehensive preventive services, proactive chronic care and risk reduction, the challenges of cancer survivorship, increasingly complicated multimorbidities, and integration of care for mental symptoms and disorders, along with the usual panoply of acute complaints. An individual physician can no longer provide all of the care required by contemporary expectations. In a reformed system of patient-centered, accountable care, the patient will belong not to the physician but to the entire practice.

Care teams have been proposed for a number of years but have generally focused on delegating some of the physician's tasks to staff instead of imagining new value-added activities. To achieve the potential of primary care in a truly reformed health care system, the entire practice must function effectively around the tasks of primary care as defined by the needs and preferences of patients. Practice staffing needs to be reconfigured so that each staff member contributes uniquely to the patient experience and each brings a specific and unique value to the patient visit. Practice staff should be hired at least in part on the basis of their affinity for collaboration and should be trained to work collaboratively to the best of their abilities, focused on meeting the diverse needs and preferences of their patients.

THE MEDICAL HOME AS A LEARNING ORGANIZATION Practices must adopt a different shared vision of the work they do. Instead of seeing themselves as organizations that process patient visits for the physician, patient-centered medical homes need to see themselves as organizations that employ an expanded set of skills and that improvise to meet the needs and preferences of their patients. As collaborative care teams are established, both within the practice and across the health care neighborhood, the structures and processes within practices need to encompass reflective sensemaking, in which people give meaning to their experiences, improvisation, and continual organizational learning.

The dual-organization management model and the primacy of patient flow impede this process. To improve reflection and learning, physicians must give up the "conspiracy of autonomy" that isolates them from each other within a practice and from their care team. This tendency for physicians to maintain autonomy inhibits the kind of communication that shines light on clinical processes and that would allow the clinicians

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to be accountable to each other and to help each other continually improve the quality of care delivered by the practice.

The dual-organization patterns that we commonly see also impede honest communication and group inquiry among members of the care team, and they can serve to hide patterns of deficient care on either side. Since all members of the practice have contact with patients and have unique views of patients' needs, enhancing the honest flow of information reinforces an important source of informative, reflective conversation about patient care.

THE MEDICAL HOME AS A GOOD CITIZEN OF THE HEALTH CARE NEIGHBORHOOD The health care neighborhood should be seen as more than the referral network for the primary care practice. Rather, it should be seen as a network of those diverse services that can be mobilized according to patients' needs and preferences. We hope that accountable care organizations will create health care neighborhoods by explicitly bringing together in a shared business model those resources that currently exist but do not collaborate according to patients' needs.[2]

As a network, the health care neighborhood must move resources and information in a manner that is unique to each patient's needs and preferences. Instead of expecting the primary care practice to keep patients from falling through the cracks, the health care neighborhood should develop in a way that largely eliminates the cracks. Nonetheless, the practice must become adept and nimble at forming innovative care teams, both within the practice and in teams across other service agencies within the health care neighborhood. Such care teams will need to continually adapt and reconfigure themselves as patients' needs and preferences change and suggest new value-added services for primary care practice staff.

Thus, being a good citizen of the health care neighborhood requires the patient-centered medical home to be nimble; capable of continuous learning; and adept at self-assessment, reflection, and improvisation.[16]

Overcoming Barriers To Change In Small Primary Care Practices

PAYMENT REFORM The current fee-for-service environment in which most small primary care practices exist exacerbates some of the troublesome characteristics, especially the focus on patient flow and the emphasis on midlevel clinicians' generation of fee-for-service revenue. Payment reform alone, however, will not necessarily lead to an environment in which the principles for rethinking primary care can take shape.

We have previously described a staged approach to payment reform that supports the transformation of small primary care practices into patient-centered medical homes.[17] At the first level, enhanced fee-for-service or robust performance payments, or both, can provide up-front support for small practices to add elements of a patient-centered medical home that represent incremental changes to the current practice model. At the second level, bundled payment for episodes of ambulatory care, rather than paying by the visit, could incentivize the involvement of other health care professionals and facilitate the identity shifts required for establishing functional care teams for planned, proactive, population-based care.

Finally, the third level of development of patient-centered medical homes—consistent with the principles outlined above—requires a major shift in the mental models of physicians to achieve a new paradigm of primary care in which the practice is integrated within a larger health care neighborhood. To reach this new paradigm, practices must transform to become highly nimble organizations that work seamlessly as part of the local health care neighborhood to contribute to the health of defined populations. Accomplishing this third level of development is likely to require support and risk-sharing incentives. These incentives may well take the form of per member per month payments. We certainly encourage the active development of new and imaginative payment systems that facilitate the mental model changes required to deliver the kind of primary care we envision.

NEW MENTAL MODELS Payment reform is a necessary but not sufficient ingredient for bringing about change to the US health care system. A per member per month payment structure can create an environment in which small practices might get off the hamster wheel and turn their attention to the important principles for redesigning primary care.

In evaluating the American Academy of Family Physicians' National Demonstration Project on patient-centered medical homes, we observed important instances in which practices made much progress in the transformation to a patient-centered medical home.[15] In virtually every instance, the mental models of physician leadership changed dramatically. This most often involved rethinking the mission and strategies of the practice; embracing the need for a meaningful care team approach; and adopting a proactive, population-based approach to care. In most of our work with more typical small practices, however, we have only rarely observed similar transformations among physician-leaders, particularly without sustained external support.

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Shifting the mental models, particularly of the physicians, in small primary care practices will be a monumental undertaking. Our work suggests that practice staff members will also require a great deal of assistance in achieving the mental models required of a patient-centered medical home, because they also were not trained to work in a collaborative team environment.

Tools and approaches for changing mental models exist.[18–20] These require time and space for regular reflection, rich conversations about practice values, and a shared vision of the mission.

To assist small primary care practices, the primary care professional organizations must step forward and understand their role as much more than advocating for a more favorable reimbursement structure for physicians. They should embrace, with equal enthusiasm and dedication, the need to promote new approaches to doctoring and to the design and management of practices. Such a transformation will require new strategies, workshops, and other learning and personal development formats to help physicians transform themselves and their relationships with their practice partners, staff, patients, health care systems, and communities.

Conclusion

We believe in the values and traditions of primary care. But we do not believe that the current culture of most small primary care practices is compatible with changes that are required in a truly reformed health care system. Reimbursement reform is a necessary but not sufficient ingredient and must be accompanied by monumental efforts to change the paradigm of primary care and the mental models of many primary care physicians.

We share with our primary care colleagues a deep and abiding respect for the task of primary care and the rich heritage and values of healing relationships between primary care physicians and their patients. Fulfilling the expanded task of primary care in the patient-centered medical home, however, now asks physicians to work in new ways and to lead change in the dominant culture of their practices. ■

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Paul A. Nutting is the director of research at the Center for Research Strategies, in Denver, Colorado.

In this month's *Health Affairs*, Paul Nutting and coauthors, who have studied more than 400 small primary care practices, describe four characteristics of such practices that they say will seriously inhibit practices' transformation to this new care model. In their research, they found that small practices were extremely physician-centric, lacked meaningful communication among physicians, were dominated by authoritarian leadership behavior, and were underserved by midlevel clinicians who had been cast into unimaginative roles. The authors see little prospect of success unless primary care physicians can adopt new mental and operating models that focus a complex set of primary care–related tasks on meeting the needs and preferences of patients.

Nutting, a family physician with forty years of experience in primary care and health services research, has been a professor of family medicine at the University of Colorado Health Sciences Center since 1993 and the director of research at the Center for Research Strategies, in Denver, since 1999. He was affiliated with the Indian Health Service's Office of Research and Development in various capacities in the 1970s and 1980s and was both deputy director of the Center for General Health Services Research and founding director of the Division of Primary Care with the Agency for Healthcare Research and Quality.

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