Patient-Centered
Primary Care
COLLABORATIVE

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PCPCC LEADERSHIP RESPONDS TO JAMA ARTICLE ON MEDICAL HOME PILOT STUDY

February 26, 2014 (WASHINGTON, DC) – As the leading coalition dedicated to advancing the medical home, the Patient-Centered Primary Care Collaborative (PCPCC) offers the following response to the articles in today's Journal of the American Medical Association: "*Association Between Participation in a Multipayer Medical Home Intervention and Changes in Quality, Utilization, and Costs of Care,*" by Drs. Friedburg, Schneider, Rosenthal, Volpp, and Werner, and the accompanying editorial, "*The Patient-Centered Medical Home: One Size Does Not Fit All,*" by Dr. Schwenk.

The study's authors conclude that, "a multipayer medical home pilot, in which participating practices adopted new structural capabilities and received NCQA certification (recognition), was associated with limited improvements in quality and was not associated with reductions in utilization of hospital, emergency department, or ambulatory care services or total costs over 3 years. These findings suggest that medical home interventions may need further refinement." Dr. Schwenk offers that "advocates for this model of care need not be disappointed [in the paper's conclusions] but should pay close attention to the study's lessons."

"We agree – continued refinement of the medical home recognition process is critical as we learn what features or attributes of the model lead to the "triple-aim" goal of lower costs, better patient experience of care, and better population health outcomes," said PCPCC CEO Marci Nielsen, PhD, MPH. "This pilot study makes an important contribution because it highlights that the NCQA-recognized pilot practices made structural changes that were necessary, but perhaps not sufficient, to reducing the total cost of care and utilization of emergency departments and hospitalization. In fact, the pilot practices did not offer weekend care or evening care. Since improved access to care is one of the key features of a medical home, it is fair to question whether these pilot practices had yet transformed to be true medical homes."

Other examples of key features of the patient-centered medical home (PCMH) that were missing from this pilot were measures related to patient-centeredness (patient engagement, satisfaction, or activation), team-based care, and behavioral health integration. Moreover, recognition as a PCMH is not necessarily synonymous with being one. As McNellis et al. describe in their commentary of several primary care practice transformation studies, "a practice could be a true PCMH without having received recognition, and a practice that has received PCMH recognition may not be a true PCMH." Although a number of the individual elements of the medical home are well-grounded in the literature, the evidence base for which components of the model are most important in terms of impacting patient outcomes, high performance, operational feasibility, and sustainability, is still being developed by the health services research learning community. Accordingly, the requirements for recognition/certification must continue to evolve.

A persistent challenge in achieving a true patient-centered medical home lies not only in meeting the "basic requirements" for recognition/accrediting programs – which continue to be updated and can help serve as an important roadmap for practices to transform -- but also equipping practices and health systems with the capabilities to continually reassess and improve care delivery in response to the changing health needs of patients and their families. The health care marketplace must also move away from a volume driven fee-for-service payment model to one driven by value as proposed in the bipartisan, bicameral Sustainable Growth Rate repeal legislation being considered by Congress.

Additional limitations to the otherwise well-conducted study include the following:

- The study did not reference the recent PCPCC annual report which analyzed 13 peer-reviewed and 7 industry studies and found cost savings and utilization reductions in over 60% of the evaluations (http://www.pcpcc.org/resource/medical-homes-impact-cost-quality).
- In terms of the pilot's design, there were no financial incentives to control costs despite the financial incentives to become NCQA recognized.
- There was a very low response rate from the non-NCQA recognized practices (24% as compared to the pilot practices, which had a 91% response rate) making it difficult to draw comparisons between the two groups.
- There was no targeting and/or analysis of chronically ill patients. With 5 percent of the population accounting for nearly half of all health costs, it is important to target those who are determined to be most at-risk– especially for interventions intended to reduce costs.

About PCPCC: Founded in 2006, the mission of the PCPCC is to advance an effective and efficient health system built on a strong foundation of primary care and the Patient-Centered Medical Home. The PCPCC achieves its mission through the work of its five Stakeholder Centers, dedicated volunteer groups focused on issues of U.S. health care transformation through delivery reform, payment reform and benefit redesign. Today, PCPCC's membership represents more than 1,000 stakeholder organizations and 50 million health care consumers throughout the U.S. Our activities include: disseminating results and outcomes from medical home initiatives, advocating for public policy that advances and builds support for primary care and the medical home, and convening health care experts and thought leaders from across the private and public sectors.

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