Medical Homes May Not Be the Answer

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A patient-centered medical home (PCMH) demonstration project did little to reduce costs and utilization or improve the quality of care, researchers found.

The 3-year study of 32 small- and medium-sized primary care practices -- believed to be the first multi-payer pilot in the nation to report results over 3 years -- found that the use of a PCMH model didn't reduce hospitalizations, emergency department use, ambulatory services, or costs, according to a report in the *Journal of the American Medical Association*.

Furthermore, the practices showed improvement in only one of 11 quality measures -- nephropathy screening in diabetes patients -- relative to 29 comparison sites, according to Mark Friedberg, MD, of the RAND Corporation in Boston, and colleagues.

The research should be alarming to backers of the delivery model who claim the PCMH design is the future of primary care delivery, they wrote. "These findings suggest that medical home interventions may need further refinement."

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Action Points

- This is a study of volunteering primary care practices that participated in a medical home pilot project over a 3-year period.
- Pilot participation was associated with statistically significantly greater performance improvement, relative to comparison practices, on only one of 11 investigated quality measures.
- Pilot participation was not associated with statistically significant changes in utilization or costs of care.

The researchers studied the implementation of the Pennsylvania Chronic Care Initiative from June 2008 to May 2011. The pilot program gave practices on average $92,000 per physician to help them become certified as PCMHs by the National Committee for Quality Assurance (NCQA). Three private insurers

and three Medicaid managed care plans participated.

More than 64,000 patients were attributed to the pilot practices and nearly 56,000 to the comparison practices.

Friedberg and colleagues found that the practices adopted structural changes to their work. However, those changes did not create statistically significant reductions in cost or utilization measures -- such as hospitalization -- that PCMHs strive to create.

For example, total cost of care went from $389 per 1,000 patients per month before the pilot to $430 per 1,000 patients per month in year three of the pilot.

Support for PCMHs is widespread despite the lack of evidence supporting the model -- from this *JAMA* study and others like it.

"It is time to replace enthusiasm and promotion with scientific rigor and prudence and to better understand what the PCMH is and is not," Thomas Schwenk, MD, dean of the University of Nevada School of Medicine in Reno, wrote in an accompanying editorial. "Widespread implementation of the PCMH with limited data may lead to failure."

Instead, the study should remind the healthcare community that providers' focus should be on high-need patients, he said.

A quarter of all medical care is consumed by 1% of the population, according to the Agency for Healthcare Research and Quality. And nearly half is consumed by 5%. It's those patients who would benefit from extra care management and oversight that are usually trademarks of PCMHs, Schwenk wrote.

Marci Nielsen, PhD, chief executive of the Patient-Centered Primary Care Collaborative (PCPCC), told *MedPage Today* that she agrees with the assessment Schwenk made that lessons must be learned from the results.

For example, the pilots in the study mostly did not offer weekend or evening hours, and the measure of access was new patients being able to schedule an appointment within 2 weeks.

"It is fair to question whether these pilot practices were in fact true medical homes," Nielsen wrote in an email. "There were also no measures reported in the pilot related to patient-centeredness, team-based care, and behavioral health integration."

The PCPCC released a study last month that showed sparse levels of improvement in overutilization and patient satisfaction, with slightly greater results in reducing costs and emergency department visits.

George Jackson, PhD, of Duke University School of Medicine, said it's not yet clear which PCMH tools work best and in what situations.

"There's a lot more that needs to be learned about what specifics need to be put in place to make the patient-centered medical home real," Jackson told *MedPage Today* in a video interview.

But the concept of how to delivery primary care should not be discarded because of a study or two, Jackson said.

Jackson and colleagues concluded in an article in *Annals of Internal Medicine* last year that "current evidence is insufficient to determine effects on clinical and most economic outcomes" of PCMHs.

Asaf Bitton, MD, MPH, instructor of healthcare policy and PCMH researcher at Harvard Medical School, said researchers should not be asking whether a medical home works. Instead, PCMHs should be seen as complex and heterogeneous efforts.

"I think it is interesting to note that three recent null studies in this area all used NCQA recognition to guide and measure transformation," Bitton told *MedPage Today* in an email. "There has been a fair amount of discussion recently about whether this set of standards, which is by far the most widely used set in the country, is overly broad and too much of a 'check the box' type of activity that may not accurately reflect or promote the most rigorous types of high value transformation associated with best results."

Friedberg disclosed relevant relationships with the Department of Veterans Affairs and the

Patient-Centered Outcomes Research Institute. Coauthors disclosed relevant relationships with with CVS Caremark, VALHealth, Humana, Horizon Blue Cross Blue Shield, Weight Watchers, Discovery (South Africa), the Veterans Health Administration, Horizon, and Healthcare Innovation.

Schwenk disclosed no relevant relationships with industry.

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Source reference:Schwenk T "The patient-centered medical home: One size does not fit all" *JAMA* 2014; 311(8): 802-3.

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