The patient-centered medical home (PCMH) model as a means of organizing primary care practice has been gaining adherents for several years now. Its aims are threefold:

- to provide patients with high-quality primary care, assistance in meeting their health goals, care coordination, and encouragement to become more active in managing their own care;
- to preserve, sustain, and modernize the primary care practice, improving both patient and staff experience;
- to increase practice efficiency and reduce costs through attention to prevention and wellness, care management, use of health information technology, and tailoring resource use to patient need.

The Agency for Healthcare Research and Quality (AHRQ) characterizes a PCMH as being accessible, coordinated, comprehensive, systems-based, and patient-centered.¹ Common features of a PCMH include team-based care, an electronic health record system, care coordination across care settings, and enhanced communication between patient and provider.

Some health plans, notably WellPoint and Aetna, offer enhanced reimbursement to primary care practices that qualify as medical homes. While the Centers for Medicare & Medicaid Services (CMS) does not explicitly use the term PCMH, its Comprehensive Primary Care Initiative (CPCI) offers care management fees to participating practices in exchange for enhanced service to Medicare beneficiaries. According to the National Academy for State Health Policy, 43 state Medicaid programs have adopted policies to advance medical homes for their beneficiaries.²

Originating with the American Academy of Pediatrics some 40 years ago, the medical home was conceived as a framework to...
offer care and record-keeping for children with special health care needs. In more recent years there has been some disagreement as to whether the use of the PCMH model should be targeted or all-inclusive. As Robert Berenson and colleagues have pointed out, there is a lack of evidence on whether the medical home model makes sense for all types of patients or a subset thereof, such as high-risk patients with multiple chronic diseases.3

Some analysts look to PCMH to help move primary care practice in the direction of population-based health management. In this vision, a PCMH (possibly as part of an accountable care organization, an ACO) would keep track of a panel of patients in all states of health, maintaining registries to flag service needs and allowing analysis of care provided.

Practices continue to seek recognition as PCMHs from NCQA (National Committee for Quality Assurance) and to participate in government- and health plan-sponsored PCMH pilots. This proliferation naturally raises the question of how much difference medical homes are actually making to cost, quality, and patient and provider experience. Answers are mixed. “We have saved,” say some, or “our doctors are really happy,” or “patients love it.” Others say, “well, not that much has changed,” or “it is early days for evaluation.”

A literature review by George L. Jackson and colleagues found that research to date on effectiveness is inconclusive. The authors note that definitions and nomenclature are inconsistent across research studies, and that studies varied widely in the range of outcomes reported and the specific measures used. While acknowledging that the PCMH holds promise for improving the experience of patients and staff and potentially for improving care processes, the review ultimately found that current evidence is insufficient to determine effects on clinical and most economic outcomes.4

Some health plans and practices have been able to document quality improvement and savings in their first measurement period. For example, an independent evaluation of the Capital District Physicians’ Health Plan’s Enhanced Primary Care program found that practices in its pilot saw a savings of $8 per member per month in total medical costs as well as reductions in hospital admissions, emergency department (ED) visits, and advanced imaging. CareFirst BlueCross BlueShield reported in June that its medical home trial had achieved savings of $98 million (2.7 percent) compared with projections for 2012.5 WellPoint similarly logged reductions in admissions and ED visits in its Colorado pilot.6
Despite the ambiguous evidence, support for the PCMH concept continues. Both physician and health plan leaders have expressed enthusiasm for something they can use to open a conversation with clinicians about transforming practice. This may encompass changing workflows, shifting responsibilities, undertaking quality improvement programs, adopting new communication modes, engaging with patients in shared decision making, and building links to community-based services.

Even those who have logged successes are in agreement that transformation, though necessary, is neither quick nor easy. Whether the PCMH proves itself the right vehicle remains to be seen. But even at this early stage, lessons both positive and negative are being learned. This Forum session will explore some of those lessons.

**SESSION**

**George L. Jackson, PhD, MHA,** an epidemiologist and assistant professor at the Duke University School of Medicine, summarized the results of his recent review of the PCMH literature. He described the potential outcomes of other research still in progress and provided practice examples from his experience with the patient-aligned care teams that are the Department of Veterans Affairs’ version of PCMH.

**Bruce Nash, MD, MBA,** senior vice president, medical affairs and chief medical officer of the Capital District Physicians’ Health Plan talked about how his group has used PCMH as a construct around which to build not just a new kind of practice but (in time) a new kind of health care marketplace. **Lewis G. Sandy, MD, MBA,** senior vice president, clinical advancement for UnitedHealth Group, talked about his company’s PCMH experience in multiple markets around the country, including participation in CPCI, and what he has learned about factors apt to be associated with PCMH success.

**KEY QUESTIONS**

- What benefits do clinicians seek through adoption of the PCMH model? What are some of the concerns they have faced in adoption/implementation so far? What are patient attitudes to this transformation and their role in it?

- Is the PCMH model more suited to some types of patients than others?
• What clinician and practice characteristics may help to ease the transition to PCMH and lead to successful implementation?

• How can services such as pharmacy and mental health be integrated into the PCMH? What about social support services?

• What has been learned about modes and levels of reimbursement conducive to PCMH success?

• To what extent will the PCMH model be effective in offsetting the competitive pressures that many practitioners see as eroding their professional autonomy?

• What will drive future PCMH evolution?

ENDNOTES


5. CareFirst BlueCross BlueShield, “Patient-Centered Medical Home Trims Expected Health Care Costs by $98 Million in Second Year;” June 6, 2013, available at https://member.carefirst.com/wps/portal/!ut/p/c5/04_SBBK8xLLM9MSSzPy8x-Bz9CPoos3hJbzhQ09LiywN2rSHA09fly97Fx8fAwXM688JG55f00KdbsRo9sAB3A0l-KA7HORVcrwyoP8hifeCCK371-Hvm5toyfUuahGhEqzSrQdiooA22r1Vg1/dl3/d2/L2dIQSev UUt3SQ9zQnZjsZFOUzsZ2fJDOMw70RIMTBJThVQHsUlIeQnQTYy/?WCM_GLOBAL__CONTEXT=wcmcwps/wcm/connect/content-member/carefirst/memberportal/medianews/popup/medianews20130606.