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FROM THE EDITOR

Patient-centered Medical Home: Does the Evidence Support the Change?

Priya Radhakrishnan, MD

A recent systematic review in *Annals* of the patient-centered medical home (PCMH)[1] has raised questions about whether this transformation is indeed improving our ability to reduce costs. As a strong supporter of the PCMH, I am not surprised by this assumption for a few reasons.

First, the PCMH transformation, which historically can be traced to the 1960s in Hawaii as a mechanism for payment reform, has only very recently been adopted in a more robust way. Many of the initial PCMHs were very broad and focused on quality outcomes, such as hemoglobin A1c and other preventative health measures. To realize these outcomes, it will take several decades and systematic longitudinal studies to assess the cost and impact.

Next, many pilots funded by insurance plans have not published their results. In the state of Arizona, one of the state Medicaid programs has developed a PCMH in partnership with practices that have a high proportion of high-cost Medicaid patients. In our health system, we have seen a 10% to 33% reduction in emergency room visits and inpatient admissions across our sites. To measure the cost impact, it is vital that pilots be studied systematically as a partnership of insurers, employers, and hospital systems.

Additionally, quality improvement in health delivery may require several cycles to "get it right" and produce generalizable information. Based on our experience in our clinic, the design and refinement is still ongoing. The biggest challenge that we have experienced is the lack of knowledge on how to review and develop action plans with raw data. For example, when we started our diabetic process improvement project, each physician in the practice received a list of 250 to 500 patients to review. Serendipitously, we found a systems analyst who created rules for reporting data, thus shrinking the list to a single page of actionable items. It is crucial for programs to partner with data analysts to ensure that the correct data are being collected and managed.

Finally, institutional culture has a big role to play in the success of the PCMH. From a culture of ordering every test for every ailment, we are now pausing to question whether the test is needed. One of the core PCMH standards requires that practices follow up on results. The simple act of forwarding an echocardiogram to the next provider will cost our health system millions of dollars when we count the millions of repeat echocardiograms performed for every congestive heart failure admission. How do we study such a change?

Before all the critics wave their flags and say "I told you so—it was too onerous, and the data do not support it," pause and consider the measurement issues. We do not have the correct yardsticks or information to make the call just yet. In the words of Arthur Conan Doyle, author of the Sherlock Holmes books, "It is a capital mistake to theorize before one has data. Insensibly one begins to twist facts to suit theories, instead of theories to suit facts." Before we write off the PCMH as yet another fad that does not work, we need to ensure that we have given it sufficient time to flourish, study, and improve.

Reference

1. Jackson GL, et al. The patient-centered medical home: a systematic review. Ann Intern Med 2013; 158(3):169-78.

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