Patient-Centered Medical Homes- the latest research findings: commentary from BCBSM

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March 6, 2014

Recently, a three year evaluation of a medical home pilot was published in JAMA that found limited effects of the medical home. On the surface, these findings run counter to the Health Services Research Journal study first published in July 2013 showing positive impacts on cost and quality of the Blue Cross Blue Shield of Michigan PCMH program – which translated into roughly $155M in savings over the program's first three years.

However, there are potentially key reasons why these studies yielded different results: 1) The PCMH programs are designed and administered differently; 2) The programs were implemented in different settings.

Not all PCMH programs are the same

Translating theory into practice is always a challenge, and such is the case with the Patient-Centered Medical Home (PCMH). Because this translation is still in its infancy, there is neither a standard set of criteria nor a "gold standard" that defines what constitutes a "Patient Centered Medical Home". As a result, studies of the impacts of "PCMH" are not always directly comparable to one another, either due to differences in how medical homes are defined or due to the contexts in which they are implemented.

In the past few years, several definitions of PCMH have arisen – two of which are the NCQA PCMH and the BCBSM PCMH. An Urban Institute study in 2012 compared several PCMH recognition programs. The two excerpts below shows the findings from that study, and demonstrate some of the similarities and differences between the BCBSM and 2008 NCQA program implemented in Southeast Pennsylvania.

> ***Blue Cross Blue Shield of Michigan PCMH program:*** "This tool seems most suited to serving double-duty as a practice self-improvement tool. This is because the tool does not merely ask a question like "Do you have a patient registry?", but instead presents a whole suite of questions about registries, outlining in a more granular level of detail than the other tools the specific activities that practices should be doing with their registries.
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> This tool also includes more specific (and frequently, ambitious) performance expectations in their standards – for example, the tool doesn't just ask if same-day scheduling is available, instead it specifies that 30% of appointments should be reserved for same-day appointments; it doesn't just ask whether patients can speak with a clinician after-hours, instead it specifies that after-hours calls from patients should be returned within 15-30 minutes, and within 60 minutes at maximum.
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> In terms of content, this tool opted not to spread its items across a variety of content domains(as other tools, such as the Joint Commission's, did) and instead targeted a few areas more deeply: population management (18%), care coordination (16%), and patient engagement and self- management (13%), health IT (12%), and quality measurement (11%)."
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> ***2008 NCQA PCMH Recognition Program***: "The most notable feature of NCQA's 2008 standards is the heavy emphasis on the use of health IT, at 46% of the tool's items (or 30% of its score). Other content domains with high levels of emphasis are care coordination (12% of items, or 17% of the score), quality measurement (7% of items, or 11% of the score), and access to care (6% of both the items and the score).
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> An obvious strength of NCQA's tool is its widespread use by a variety of plans and providers across the country – including Medicaid and state programs, multi-payer efforts, community health centers, federally qualified health centers, and military treatment facilities. Because of its wide use, sponsors of PCMH initiatives could potentially compare their practices' performance using the NCQA 2008 standards to that of other providers who used those standards in their demonstrations or initiatives – though scores on the 2008 NCQA survey are not comparable to scores on the 2011 NCQA survey, due to differences in question wording and scoring cut-offs for different NCQA medical home levels.

The biggest drawback of the 2008 NCQA tool is its burdensome documentation requirements, which NCQA estimates takes 40-80 hours to comply with (just in terms of time to upload the documentation into their online survey tool). NCQA has also been criticized for its high price"

Why might the Michigan program be demonstrating impacts while the Pennsylvania program showed limited effects?

The BCBSM program has significant financial incentives tied not just to implementation of the PCMH model, but also to improved patient outcomes. For a PCMH designated physician, significant reimbursement is tied to maintaining or improving patient outcomes. No such incentive existed in the Pennsylvania PCMH program.

The BCBSM program is significantly invested in ensuring rigorous implementation. BCBSM conducts a random sample of over 200 practice site visits each year where practices have to demonstrate the use of PCMH capabilities in practice, while the Pennsylvania program relied on self-reporting.

Primary care practices participating in the BCBSM PCMH program are heavily invested in key processes around extended access such as open scheduling and after-hours access – which could have strong impacts on emergency department use. Very few of the Pennsylvania practices added capabilities around access in the three years of implementation.

Context matters

The Southeast Pennsylvania study was limited to roughly 30 volunteer practices implementing PCMH according to the NCQA model. Like many studies of small self-selected practices, it is difficult to generalize these results to other settings. Because nearly 2,500 primary care practices in Michigan are implementing a different model of PCMH and across a wide variety of settings (urban, rural, low SES, high SES, independent practices, hospital-owned practices, etc.), we expect that evaluation results from the two programs could differ substantially.

Study differences

A key difference with the Southeast Pennsylvania PCMH study and the Michigan study is the time lag between implementation and expected changes in patient outcomes. The Michigan experience is that it takes at least a year if not more to fully integrate these processes into routine patient care once adopted – no such lead time was accounted for in the Southeast Pennsylvania study. Also, Pennsylvania practices only had to achieve level I NCQA PCMH recognition, the lowest level of three, by the end of the second program year. This level of PCMH-ness is substantially less than that represented by BCBSM PCMH Designation status in both breadth/depth of medical home capabilities and in the duration of their use in practice.

While the Southeast Pennsylvania study did use comparison practices for their evaluation, they did not have adequate information about the extent to which these comparison practices were practicing like a PCMH. Hence, it is unclear what the difference between the pilot and comparison practices truly reflects. In the Michigan study, we had information on the PCMH processes used by all practices in the study.

Questions about this article can be directed to the contributors below:

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