The Patient-Centered Medical Home: Current State of Evidence

The following is a synopsis of "The Patient-Centered Medical Home. Closing the Quality Gap: Revisiting the State of the Science," a July 2012 report published by the Agency for Healthcare Research and Quality.

What is already known on this topic?

The patient-centered medical home (PCMH) is an emerging health care delivery model that aims to provide quality health care that improves patient outcomes and reduces costs, particularly for chronic disease management and prevention. A comprehensive PCMH typically focuses on whole-person and team-based care, sustains partnerships, and reorganizes delivery. It has at least two of the following components: enhanced access, comprehensive care, coordinated care, and systems-based strategies to improve quality and safety. The PCMH model may be a promising pathway to improved primary health care quality, safety, efficiency, and effectiveness.

What is added by this document?

This systematic review analyzed 58 studies of completed or ongoing PCMH evaluations based in primary care settings. The review aimed to summarize current evidence for the PCMH model and identify evidence gaps. The authors sought to determine which patient or staff experiences, processes of care, clinical outcomes, economic outcomes, or unintended consequences were associated with the PCMH model and its strategies. Another aim of the study was to conduct a "horizon scan" to identify and assess ongoing PCMH studies, which will increase the evidence base on PCMH in the near future.

Compared to usual care or any other quality-of-care interventions, PCMH interventions adopted several strategies to improve access to services and preventive care, including home visits, group visits, and online or telephone disease management.

Evaluations of PCMH effectiveness were limited, mostly due to evaluations still in progress and heterogeneity among studies. Most evaluations were conducted in populations of older adults with multiple chronic illnesses; these particular studies showed a tendency toward mortality reduction, but it was not statistically significant. Overall, studies showed positive effects on patient and staff experiences and processes of care, although no specific PCMH strategies were associated with these outcomes. There were too few studies to estimate effects on clinical or most economic outcomes.

Thirteen studies did report on cost reduction, but none demonstrated robust evidence. However, studies did demonstrate the potential for PCMH to reduce costs through lower inpatient and emergency department use, thus suggesting the possibility of cost savings especially for certain populations that are older, sicker, and at high risk.

What are the applications for these findings?

Programs and policy efforts may use the summary of evidence from this report to:

- Develop and implement appropriate PCMH strategies.
- Guide the establishment of specific roles and responsibilities for providers in team-based care.
- Explore strategies to enhance access to care, value-added financial models, organizational learning, and implementation.

What are the implications for public health practice?

The PCMH is a patient- and family-centered, whole person–oriented, emerging model focused on improving population health through primary care–based quality health care.

Several programs and policy efforts across the nation have implemented a variety of PCMH interventions. Although studies indicate improved patient and family satisfaction and better process of care, intensive evaluation is needed to assess effectiveness of the PCMH model, especially for clinical outcomes, mortality, and economic outcomes. Such evaluation will help ensure that the efforts of providers and payers to adopt the PCMH model are worthwhile in the primary care setting and will clarify which interventions and strategies can achieve the greatest public health impact.

Further research also is needed to assess:

- The evidence gaps found in completed PCMH evaluations.
- The effectiveness of the PCHM model in pediatric or general adult primary care populations.
- Staff retention and unintended consequences, such as increased provider burden (e.g., unlimited access to providers through 24/7 coverage) and potential patient safety risks (e.g., patients using e-mail for emergency medical issues).

Resources

National Committee for Quality Assurance
Patient-Centered Medical Home
www.ncqa.org/tabid/631/Default.aspx

Patient-Centered Primary Care Collaborative
Joint Principles of the Patient-Centered Medical Home
www.pcpcc.net/content/joint-principles-patient-centered-medical-home

American College of Physicians
Patient-Centered Medical Home
www.acponline.org/running_practice/pcmh

American Academy of Family Physicians
Patient-Centered Medical Home Check List
www.aafp.org/online/etc/medialib/aafp_org/documents/membership/pcmh/checklist.Par.0001.File.tmp/PCMHChecklist.pdf

Citation

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The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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