Capsule commentary on Rosenthal et al., A Difference-in-Difference Analysis of Changes in Quality, Utilization and Cost Following the Colorado Multi-Payer Patient-Centered Medical Home Pilot

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The patient-centered medical home (PCMH) model has been touted as a transformative vehicle for primary care, potentially delivering the 'triple aim' of improvements: quality in chronic illness management, satisfaction for provider and patient, and cost savings. Good PCMH models are designed to address existing practice limitations covering the following targeted areas: access, patient-provider continuity, shared decision making, patient engagement, team-based care, patient and provider experience, and frequency of unscheduled visits. As of 2014, the National Committee for Quality Assurance had recognized nearly 700 (~10%) of U.S. primary care practices as delivering a PCMH.[1] However, the overall evidence base reveals that achieving the 'triple aim' remains an elusive target, with reproducible gains largely limited to improvements in provider and patient satisfaction. The hypothesized economic gains and standard measures of medical quality delivery have yet to be fully realized.

In the context of the published literature on PCMH, the article by Rosenthal et al. addresses cost and quality limitations of the prior published PCMH implementation studies.[2,3] The article provides a detailed 3-year post-implementation difference-in-difference analysis examining quality, cost, and utilization outcomes between 15 pilot sites and 66 control sites within a multi-payer system in Colorado covering 291 team members and 100,000 patients. Relative to controls, the pilot sites showed lower rates of emergency room (ER) visits, reduced ER costs, fewer primary care visits, improved cervical cancer screening rates, and fewer admissions for ambulatory sensitive conditions. However, the pilot sites demonstrated lower rates of HbA1c and colon cancer screening relative to the control sites.

This article reflects the promise of a PCMH model, albeit with some unintended or unanticipated consequences of implementing major transformations in practice. While achieving the 'triple aim' via primary care system redesign still remains elusive, existing evidence examining the PCMH model shows that it consistently delivers gains in patient and provider experience. Adding this article to the weight of current evidence, with careful planning and implementation, gains in cost, utilization, and important standardized medical outcomes appear to be within range.

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