



In the Literature

Highlights from Commonwealth Fund-Supported Studies in Professional Journals

Effect of a Multipayer Patient-Centered Medical Home on Health Care Utilization and Quality: The Rhode Island Chronic Care Sustainability Initiative Pilot Program

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Synopsis

An evaluation of one of the nation's first multipayer medical home pilot programs found that the five participating physician practices made great strides in building the infrastructure and care processes needed to sustain medical homes. The pilot program was associated with a significant reduction after two years in the percentage of emergency department (ED) visits for conditions that could have been treated in ambulatory care settings. It may take longer, however, for practices to see broader reductions in hospital and ED use or improvements in patient outcomes.

"The participating groups made substantial progress in . . . prospective population management and in tracking and coordination of care."

The Issue

Although some patient-centered medical home (PCMH) initiatives led by large, integrated health systems have been effective in controlling costs, recent studies have found that PCMH efforts undertaken in less-integrated settings have produced only modest or limited effects. Commonwealth Fund-supported researchers reported on the results of a medical home pilot launched in 2008 among five small, independent primary care practices in Rhode Island, with financial support provided by the state's three largest commercial insurers. Participating practices were required to obtain recognition as medical homes from the National Committee for Quality Assurance (NCQA), track and share their performance on indicators of clinical quality, and undertake quality improvement efforts. The health plans paid practices about \$3 per patient per month and supported a nurse care manager at each practice.

Key Findings

- All five practices achieved Level I recognition by NCQA as patient-centered medical homes in 2008; by 2010, two of them had achieved Level III recognition. The mean recognition score

among the five practices increased from 42 to 90 out of a possible 100 points, with notable progress in supporting patients' self-management, electronic prescribing, and tracking lab tests and results. Practices made little progress in advanced electronic communications, including secure provider–patient communication.

- The pilot was associated with a significant reduction in ambulatory care–sensitive ED visits of about 11.6 percent (from 6.9 visits per 1,000 member months at baseline to about 0.8 visits per 1,000 member months after two years).
- There were downward—yet not statistically significant—trends in the number of ED visits, hospital admissions, and ambulatory care–sensitive admissions.
- There were no significant improvements on any of the quality measures tracked for diabetes care processes and colon, breast, and cervical cancer screening, though there was some progress on some of the measures.

Addressing the Problem

In the short term, medical home initiatives may not produce cost savings. It may take longer than a few years for practices—particularly those that are not part of integrated health systems—to build the care coordination and care management infrastructure needed to achieve substantial reductions in high-cost care utilization. Payers and policymakers in Rhode Island appear to be committed to sustaining and spreading the patient-centered medical home model.

About the Study

Researchers used administrative claims data to examine changes in care processes and hospital and ED use from baseline (the two years before the intervention) to two years after the pilot's launch. Data from NCQA were used to assess changes in practices' structures and care processes. Thirty-four practices with similar patient characteristics and utilization patterns served as controls.

The Bottom Line

This pilot of a multipayer medical home among five small, independent practices was associated with a significant reduction in ambulatory care–sensitive emergency department visits. It may take longer than two years for broader reductions in hospitalizations and emergency visits, or improvements in care, to be seen.

Citation

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This summary was prepared by Martha Hostetter.