Focus on 'high-value elements' in primary care doesn't lower healthcare costs

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A redesigned patient-centered medical home (PCMH) approach focusing on defined "high-value elements" (HVEs) does not reduce healthcare costs for patients at primary care practices, reports a study in

the February issue of *Medical Care*.

Despite a trend toward decreased hospitalizations, the HVE approach was associated with an increased rate of emergency department visits and no change in total costs for patients in participating primary care practices, according to the cluster randomized trial report by David A. Dorr, MD, MS, and colleagues of Oregon Health & Science University, Portland. "*n the face of other substantial gaps in PCMH evidence to reduce cost and utilization, [the results] should push model developers and policymakers to consider substantially different approaches," the researchers write.*

Targeting HVEs improves patient experiences, but doesn't reduce costs of care

The PCMH approach—focused on providing access to comprehensive, coordinated, team-based care—is a key part of efforts to improve quality while reducing excessive costs in the US healthcare system. More than half of primary care practices in Oregon report following the PCMH model. However, its impact on healthcare costs and utilization remain unclear.

With funding from the Gordon and Betty Moore Foundation, Dr. Dorr and his team developed a new PCMH approach focusing on certain high-value elements with evidence of effectiveness in reducing healthcare costs or utilization. In initial studies, the HVE approach produced improvement in patients' experience of care. The new study evaluated the redesigned PCMH model for its ability to reduce costs of care at primary care clinics.

Eight clinics were randomly assigned to receive training or no training in the HVE approach. Clinics assigned to the new model chose from a "curated" list of HVEs identified as likely to improve patient outcomes while reducing costs and utilization—for example, team-based care for

chronic disease management for patients with multiple or high-impact conditions. Clinics in the comparison group followed standard PCMH goals.

Both the HVE and non-HVE clinics received financial incentives, health information technology support, and practice facilitation toward meeting quality improvement goals. The researchers analyzed data on healthcare costs and utilization for more than 16,000 patients. Both groups of clinics were highly engaged with their assigned approach and showed improvement toward meeting quality improvement goals.

However, there was no significant difference in costs for patients seen at HVE versus non-HVE clinics. Costs rose in both groups, with a between-group difference of only about $100 per patient.

Emergency department visits showed a small increase for patients seen at HVE clinics, compared to a significant decrease at clinics receiving the standard quality improvement approach. There was a trend toward decreased hospitalization rates for patients at HVE clinics, although the difference was significant only on comparison of monthly averages.

Despite significant research efforts, there is still only limited evidence for the use of PCMH approaches to reduce healthcare costs in primary care practice—particularly for the small group of high-need patients who account for the largest share of costs. The researchers note some key limitations of their study, including the relatively small number of practices included and the complexity of the study intervention.

Despite high levels of engagement and promising effects on patients' experiences of care, the study "did not show clear benefits to cost and utilization" with the HVE model, Dr. Dorr and coauthors write. They conclude that "the ability to change individual trajectories of patients' health with PCMH and advanced primary care models may be limited

without organizationally focused team- and patient-driven approaches."

More information: Joshua Colasurdo et al, The Transforming Outcomes for Patients Through Medical Home Evaluation and reDesign (TOPMED) Cluster Randomized Controlled Trial, *Medical Care* (2022). DOI: 10.1097/MLR.0000000000001660

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