The comprehensive article by David B. Klein, Miriam J. Laugesen, and Nan Liu evaluates the patient-centered medical home (PCMH) and questions whether this is truly a model for American health care. From my experience within the Veterans Health Administration (VHA), I concur that the components of the patient-centered medical home are valuable and provide a more effective model for U.S. health care. As the largest integrated health care system and an accountable care organization, the VHA is in a position to maximize the potential benefits of this model of care delivery. As the authors discuss, integrated health care systems have more flexibility with resources given their size and may have advantages not readily available.

In 2010, the VHA began its own large-scale primary care transformation, termed the Patient Aligned Care Team (PACT) model of care delivery, equivalent to the PCMH. The VHA had a preexisting infrastructure with elements of a PCMH, thus positioning it well for this transformation. However, it was unclear whether this would lead to further improvement in quality or cost containment.

The VHA had a reputation for high-quality care and HEDIS (Health Effectiveness Data and Information Set) performance that repeatedly outperformed commercial payers, Medicare, and Medicaid. Success in delivering high-quality care could be attributed to several key factors:
Education and training regarding PACT and team development were invaluable steps. To support care management, a national dashboard was created with ready access to comprehensive panel data for nurses and providers. We recognized that transformation required greater quality improvement capability, so we developed experiential learning opportunities for our management teams. Boston had adopted the Model of Improvement as a key methodology for continuous improvement, utilizing the PDSA (Plan, Do, Study, Act) as a key tool. In addition to having a shared vision of PACT, increasing resources, improving access to panel data, and identifying a standard methodology and capability for improvement work, we strongly believed that success would be unattainable without valuing and supporting time outside of clinical care to focus on redesign. We relied on “retreats,” partnering with facilitators, improvement advisors, and/or industrial engineers to co-design these trainings. We recognized and rewarded accomplishments through poster presentations at our annual primary care retreat and participated in the network’s “Engaged Work Team” program awarding qualified teams, an effort to expand the culture of improvement.

We are still on our journey. The challenge of engaging patients in health and wellness will necessitate skills in motivational interviewing techniques, shared decision making, and health coaching. The entire medical community must be aligned to provide seamless, coordinated, high-quality care. An underappreciated factor is how space design can enhance function and impact the patient experience. Our experience demonstrated that time, resources, appropriate timeline, and availability of usable data are all critical elements to success, similar to the authors’ conclusions. Based on very recent data at the national level, we may be beginning to appreciate a return on investment with a drop in emergency department/hospital utilization and increased cost savings, but more time is needed for a full evaluation.

Author’s Note
The views expressed in this article are those of the author and do not necessarily represent the views of the Department of Veterans Affairs.