The Impact of the Patient-Centered Medical Home on Health Care Disparities: Exploring Stakeholder Perspectives on Current Standards and Future Directions

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Abstract

Over the past decade, the Patient-Centered Medical Home (PCMH) has become a preeminent model for primary care delivery. Simultaneously, health care disparities have gained increasing attention. There has been limited research on whether and how the PCMH can or should affect health care disparities. The authors conducted qualitative interviews with key stakeholders and experts on the PCMH model and health care disparities, including grant and policy makers, accreditors, researchers, patient advocates, primary care practices, practice transformation organizations, and payers, to assess perspectives on the role of the PCMH in addressing health care disparities. The application of grounded theory and thematic analysis elucidated best practice recommendations for the PCMH model's role in addressing health care disparities. Although the majority of stakeholders support greater integration of efforts to reduce health care disparities into the PCMH model, most stakeholders view the current PCMH model as having minimal or indirect influence on health care disparities. The majority supported greater integration of efforts to reduce health care disparities into the PCMH model. As the PCMH model continues to be refined, and as the health care system strives toward improving population health, there must be reflection on the policies and delivery systems that impact health care disparities.

Keywords: patient-centered care, health care disparities, health care delivery, qualitative research, vulnerable populations, health policy

Introduction

REDUCING DISPARITIES in health and health care delivery is vital to improving population health, and this goal is embedded in both the Affordable Care Act (ACA)¹ and the Department of Health and Human Services' (HHS) Disparities Action Plan in 2010.² Numerous studies have highlighted the existence and growing magnitude of health and health care disparities, thought to contribute to the poor standing of the United States in terms of health care outcomes as compared to its international peers.^{3,4} There has been

strong support for social services and policies to address factors that contribute to, and worsen, both health and health care disparities,^{5–9} with emphasis on ensuring access to high-quality health care for all. Patient-centered care has been touted as one way to ameliorate social factors contributing to poor health.^{5,10,11}

The Patient-Centered Medical Home (PCMH) model, promoted by both the ACA and HHS, has been identified as a model of primary care delivery and structure that can improve quality and coordination of care,¹² and adoption continues to expand across the country through a variety of

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national and state-level recognition and accreditation processes. The core tenets of the PCMH model include a focus on the whole patient, team-based and coordinated care, improved quality and access, and sustainable payment reform¹³ without explicitly addressing health or health care disparities.^{14,15}

Evidence suggests that practices adhering to the PCMH model can reduce both disparities in health and health care.^{16–24} Whether the reductions in disparities noted are related to specific features of PCMH versus benefits from more broadly improving access to and quality of primary care^{25,26} has not been established. There is not only a lack of consensus on the impact of PCMH implementation on health care disparities,^{15,27,28} but also an overall understanding of the role of the PCMH model in addressing disparities.¹⁴ Prior research has been limited in breadth of stakeholder perspectives, especially so with representation from patient advocates and frontline clinicians.

This study used in-depth qualitative interviews with a broad range of key stakeholders to assess perspectives of the PCMH model's impact on health care disparities, and explored the role of PCMH in targeting health care disparities.

The goal was to better understand the appropriateness and feasibility of formally integrating attention to health care disparities into the PCMH framework and the various accrediting and recognition processes, with input from those on the ground as well as policy makers.

Methods

The study protocol was approved by the Committee on Human Research at the University of California, San Francisco (Institutional Review Board number 15-17627).

Sampling and recruitment

To achieve broad perspectives, this study included representatives from 8 categories of PCMH and health care disparity stakeholders, using an adapted version of the GRAPPP model articulated by Olayiwola et al.²⁸ The GRAPPP categories include: grant makers, researchers, accrediting bodies, policy makers, primary care practices, patient advocacy groups, payers, and practice transformation organizations (Table 1). Using purposive and reputational sampling,^{29,30} the research team identified leadership at national and state-

TABLE 1. PATIENT-CENTERED MEDICAL HOME AND HEALTH CARE DISPARITY STAKEHOLDERS AND THEIR ROLES IN UNDERSTANDING/IMPROVING HEALTH CARE DISPARITIES: BREAKDOWN OF STUDY PARTICIPANTS*

PCMH and health care disparity stakeholder(s)	Potential PCMH disparities opportunity	Sample size	Level of influence or targets included in study sample	
			State or local	National
Grant making organizations	Include disparities-centered outcomes in funding priorities and announcements; provide support in technical assistance programming	3	- [†]	+ ^{††}
Researchers	Improve and implement constructs to better collect and analyze sociodemographic and socioeconomic data in methodology, program development, and study design	4	+	+
Accrediting bodies	Consider opportunities to expand newer guidelines and standards to positively affect disparities and capture disparities-specific data	3	-	+
Policy makers	Develop and promote PCMH supportive legislation with demonstrable impact on vulnerable populations, including workforce, financial, and practice-based reforms	2	+	+
Primary care practices	Utilize electronic or other systems and practice protocols to collect patient-specific sociodemographic and socioeconomic data; design PCMH interventions and programs to address the disparities identified	5	+	—
Patients and Patient advocacy groups	Engage in practice transformation efforts with primary care practices; encourage collection of comprehensive patient demographic factors; ensure that PCMH interventions and initiatives have meaningful impact on patients and communities	4	+	+
Payers	Incentivize collecting and monitoring disparities-specific data and reducing health care disparities	3	+	+
Practice transformation organizations	Emphasize the importance of reducing health care disparities in teachings and tools for clinical transformation; prioritize quality improvement measures to include disparities-oriented interventions	8	+	+
Total		32		

*Adapted, with permission, from Olayiwola JN, Sheth S, Mleczo V, Choi AL, Sharma AE. The impact of the patient-centered medical home on health disparities in adults: a systematic review of the evidence. *J Health Dispar Res Pract* 2017;10:68–96; Table 3. Source: Authors' conclusions on opportunities for PCMH stakeholders to impact the study and reduction of disparities.

[†]Not included in study sample. ^{††}Included in study sample.

PCMH, patient-centered medical home.

based organizations, in both the private and public sector, from the above categories.

Two researchers (E.H.D. and J.N.O.) recruited participants via direct outreach to leadership at targeted organizations. Recruitment emails, including a written introductory handout on the research study, were sent by study investigators, using publicly available contact information. Interested stakeholders responded directly to the study team, who arranged interviews. All participants verbally consented for audio-recorded telephone interviews, and took part in the study voluntarily; no incentives were provided. One researcher (E.H.D.), trained in qualitative methods, conducted all 32 audio-recorded phone interviews.

Interviews and data collection

A semi-structured interview guide was developed (Supplementary Data) with 3 domains: (1) personal understanding of the PCMH model and of health care disparities, (2) whether and how current PCMH models affect health care disparities, and (3) the future role of the PCMH model in addressing health care disparities. Interviews were conducted between May and November 2016, each lasting 30 to 60 minutes. The coding team, working in tandem with the interview process, agreed that theoretical saturation was achieved after 32 interviews, thus concluding the interview process.

Interview audio files were transcribed and redacted by a professional transcription company. Two members of the research team (E.H.D. and K.D.) independently reviewed the first 10 transcripts to identify initial domains and codes grounded in the responses. A codebook was developed through an interactive process until consensus was reached on code definitions. Two team members coded all transcripts individually and came to consensus through discussion with the study principle investigator if there were discrepancies. ATLAS.ti, version 7.1.1 (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany) was used to organize and code data. Codes were grouped into 8 individual domains. Two researchers (E.H.D. and K.D.) reviewed all text within these domains and identified themes. These themes were validated by 2 additional members of the research team (J.N.O. and R.W.G.), who reviewed code counts and coded text.

Results

Participant characteristics

With the addition of snowball sampling, the research team identified participants in 61 organizations for inclusion, 32 of whom agreed to participate in the study, for a response rate of 52%. The 32 interviews were conducted with participants within the expanded GRAPPP model framework (Table 1). The intention was to include primary care practices with both PCMH and non-PCMH status: 3 had PCMH recognition by the National Committee for Quality Assurance and 2 did not. Of the 2 that did not, one had previously achieved PCMH recognition but elected not to renew.

Themes

Four major themes were identified in the analyses: (1) perceived impact on health care disparities; (2) approach to

impact; (3) role of policy initiatives in reducing health care disparities; and (4) approach to addressing health care disparities at the clinic level. Each was broken into additional subthemes (Table 2).

Theme 1: perceived impact of the PCMH on health care disparities. Respondents felt that the existing PCMH model has had some impact on health care disparities, though many felt that it was indirect and limited. A few were unsure if and how the model influences health care disparities, and very few thought the model had no effect on health care disparities. The often cited “rising tide raises all boats,” was discussed by many respondents who thought the PCMH did, at least indirectly, affect health care disparities, and appeared to drive their view of how the PCMH model impacts disparities. Grant makers and accrediting bodies were more likely to view PCMH designation as influencing health care disparities, attributing the PCMH requirements of having community resource and language services as having the potential to reduce disparities (Quotations 1–2). Policy makers and accreditors thought the PCMH model had evolved to incorporate more attention to social determinants of health (SDH), identifying attention to SDH as a proxy for reducing disparities.

Interviewees who thought the PCMH minimally influences health care disparities consistently noted that there were aspects of PCMH standards that could theoretically affect disparities, but that the model itself was not designed or intended to do so, nor did it necessitate attention to disparities. Respondents who did not think the model influences health care disparities viewed the PCMH model and health care disparities as completely separate (Quotation 5). Respondents consistently expressed that being patient-centered ought to reduce health care disparities through the focus on the individual barriers to health for each patient, but not all agreed that this had translated to reality. Across the board, even among those who thought the PCMH was addressing or could address disparities, all interviewees noted that PCMH designation could be “in name only,” or achieved by “checking boxes”; this view was most strongly acknowledged by patient advocates, practice transformation experts, accrediting bodies, and PCMH practices (Quotations 3–4). Some stakeholders questioned whether improving patient-centered care without specifically targeting vulnerable patient populations could aggravate, and not lessen, disparities, highlighting the importance of all clinics being aware of disparities in health care within their clinic (Quotation 6).

Some noted barriers to addressing health care disparities for the PCMH: lack of resources, data limitations, and inadequate focus on health care disparities. Respondents often cited inadequate staffing and reimbursement challenges, in terms of time needed to address social needs. Two intertwined barriers were lack of available data on health care disparities and a lack of appreciation for disparities in one’s own clinical practice. Without data collection, disparities remain invisible, and at the same time, acquiring the data may unearth underlying reticence to acknowledge disparities. (Quotations 7–9)

Theme 2: approach to impact. Most respondents thought the PCMH model should address health care disparities directly (Quotations 10–11), whereas very few did not think it

TABLE 2. THEMES/SUBTHEMES WITH REPRESENTATIVE QUOTATIONS

Theme	Subtheme	Quotation
Perceived impact of PCMH on health care disparities	Existing PCMH model has had some impact	<p>1. PCMH accreditor: "...patient disparities are addressed through those requirements that require organizations to determine the patient's preferred language for addressing health care needs, to consider patients' individual cultural needs, incorporating the patient and family members in the care and assessment of health literacy."</p> <p>2. Payer: "I'm a big advocate for the standards where the community family or patients are more involved in the clinic processes. ... where there's a local quality improvement committee and that includes people of color or different cultural and ethnic groups in that, I think, is - I think those are the standards that have the biggest impact on change because if somebody's sitting at your planning table who's of that community, you're going to be much more likely to address it."</p> <p>3. Practice transformation: "It's a lot of checking the box and taking snippets of screen shots...there were no actual benchmarks that had to be met in terms of how well you are providing language access."</p> <p>4. PCMH accreditor: regarding which PCMH metrics allow clinical practices to focus on disparities, "I'll be honest - you don't have to do everything to get credit. It's a menu of items and I'm not sure that those are items that people choose."</p> <p>5. PCMH practice: "...it's like... [asking] whether a screwdriver's good at pounding a nail. It wasn't built for that so it doesn't do that thing very well."</p> <p>6. Practice transformation: "...we tend to think that we are addressing disparities just by the people that we're focusing our efforts on, so we're good guys because we spend most of what we do in the safety net but I don't think we think enough about practice transformation and how you could transform a practice and make it a lot better and the disparities gap increases rather than decreases. ... the first thing is to recognize it as a problem."</p> <p>7. Practice transformation: in regard to integrating health care disparities into the PCMH model, "...just telling people it should exist is not the same as giving them a pathway to make it happen or giving them resources to make it happen."</p> <p>8. Payer: "Lack of acknowledgement if there's a disparity. Some of the disparities are linked to social determinants of health and those are not easily addressed. I think the bureaucracy's a barrier because we're all happy to work in our own little silo but the lack of coordination means that there's - might have a lot of case management but not a lot of integration."</p> <p>9. Grant maker: "Sometimes, the data's a challenge. Sometimes it's just uncomfortable and there's a little bit of cognitive dissonance."</p>
	Impact has been small or indirect	<p>10. PCMH accreditor: "Ideally, down the road, this should just be a part of regular health care."</p> <p>11. Patient advocate: "I would like Patient-Centered Medical Homes to be a stronger vehicle for reducing health disparities. I think there's a lot of potential for this model to be able to do that and in a more targeted way."</p> <p>12. Grant maker: "I am feeling a little cautious about putting too much burden on primary care practices to solve the problems of the world around them."</p> <p>13. Practice transformation: "I go back and forth between thinking, 'we need them to do more,' and 'we need them to just do their piece effectively.'"</p> <p>14. Non-PCMH practice: "...our concern is that there is a burden - everybody knows and talks now about the burden on the clinicians and the system. The regulatory burden."</p> <p>15. Practice transformation: "Accreditation standards can only go so far."</p> <p>16. Practice transformation: "I worry that primary care can't solve all of the world's problems, at least, at the same time. I worry about the pressures on the system ... pulling them in two separate directions."</p> <p>17. PCMH practice: "...[they] should require you to really evaluate your rules and see how they impact your population."</p>
Approach to impact	PCMH should more directly address health care disparities	
	Lack of consensus on how PCMH model should address	

(continued)

TABLE 2. (CONTINUED)

Theme	Subtheme	Quotation
Role of policy initiatives in reducing health care disparities	Improve awareness of existing disparities	<p>18. Policy maker: “Some of it is actually gathering the data and it’s important to have the data because if you monitor it then you are looking at it and then you can intervene, so it would be better to have data that’s stratified by subpopulations. It’s just hard to collect that data.”</p> <p>19. Non-PCMH practice: “We have to have a system in place to know where disparities are, where to get that data.”</p>
	Reducing health care disparities requires higher level policy initiatives, payment reform.	<p>20. Grant maker: “You actually have to have some metric within your payment model that’s conditional upon disparity reduction. It has to explicitly incentivize it.”</p> <p>21. PCMH practice: “I would like alternative payment mechanisms and value-based payment with a pretty broad net. ... Then, we could spend that money on whatever way we felt was necessary. We could put a clinic in the homeless shelter; we could pay for the lawyers; we could pay for clinical pharmacists. We could just change the way we provide care so that we can go where there’s going to be the most bang for the buck, even if it isn’t in things that are considered standard medical practice, like legal services.”</p> <p>22. Practice transformation: “...it’s not isolated to health care. It’s much more of the systemic issue ... so getting involved in that and representing those in the health care system is something that we should all, hopefully, be doing.”</p>
	Prioritize addressing disparities	<p>23. Grant maker: “I don’t think addressing health inequities is any one person’s responsibility. I realize it’s everyone’s responsibility, so even if you’re in a position where you only get to see the patient 20 minutes a day, maybe twice a year, you can ask yourself, ‘what is it that I am capable of doing to make sure that I’m building in as much of an equity focus into my care practice as possible.’ ... There’s always something you can do.”</p> <p>24. Practice transformation: “Policy, by itself, doesn’t bring change if it’s not easy to implement.”</p> <p>25. Patient advocate: “It would be great to see a truly patient-centered system come out that addresses health disparities and really improved health outcomes and focuses on population health and the upstream factors that affect health care.”</p> <p>26. Patient advocate: “We live in communities, we live in context, and we need more life-affirming and more just context so I’d say the people to whom it matters the most are the people. We all need to be part of getting her done, so I believe very much in grassroots work but I don’t believe it’s the job of only people who are structurally disadvantaged to correct things. I think it’s the job of all of us.”</p> <p>27. Researcher: “So, the money has been made available, these capitated payments have been made available, and then it’s, like, but is the workforce able to operate at its highest level; ... Do we have behavioral health folks, are they actually integrated, do we have community health workers? Are they skilled and doing interventions that are helpful?”</p>
	Engage communities	<p>28. Grant maker: “...[practices] exist within a community and that community has characteristics to it that the practice may or may not be able to impact, but that the community also has resources that the practice can use because, frankly, primary care practices can’t delivery all the services somebody needs in order to maintain their health.”</p> <p>29. Grant maker: “Primary care practices should be a stronger partner and leader in the community. ... The [broader] issue is – and health care can be a leader on this – is addressing the social determinants of health that really drive many of the disparities that we talk about.”</p>

PCMH, patient-centered medical home.

should; some were unsure. Of those who thought the model should influence health care disparities, the majority thought the model should integrate addressing health care disparities into the key measures of PCMH models.

Patient advocates and practice transformation experts demonstrated the strongest support of the need for the PCMH model to address health care disparities, suggesting a disconnect between what they observe and what they think should be aspired to. There were no consistent recommendations for how the standards could be modified to promote health equity; even among those who supported the PCMH model addressing health care disparities, there was much concern on feasibility and burden of expanding regulations (Quotations 12–16). There were calls for more meaningful measures of how well patient populations match the surrounding community and evaluation of effectiveness of services provided (such as interpreter services). Other suggestions included requiring primary care practices to be cognizant of their own policies, and if and how they might inadvertently worsen or contribute to disparities, but without specific ideas on how this would translate into practice (Quotation 17). Strengthening data collection to ensure primary care practices are aware of and able to act on disparities that exist, and improving integration of SDH into the standards, were also recommended (Quotations 18–19).

Theme 3: role of policy initiatives in reducing health care disparities. Although the majority of respondents supported the PCMH model being modified to address health care disparities, a common unease among respondents was that the PCMH model should not be expected to address health care disparities in isolation. Concern for too broad expectations of a PCMH clinic were consistent across all respondents, even among those who want the PCMH model to more directly affect disparities. PCMH clinics themselves were most uneasy about overreaching commitments.

Acknowledging the enormity of combatting health care disparities, respondents were consistent in one policy-level change they saw as necessary to move toward health equity – payment reform (Quotations 20–21). Related to the noted barrier of resources and reimbursement, the need to incentivize primary care practices to address health care disparities and provide them with the resources to be able to do so long term was a consensus for all. Some respondents were quick to acknowledge that payment reform by itself will not translate into a reduction in health care disparities, with guidance needed on how to best direct funds. There also were calls for those working within the PCMH to be advocates for health equity in terms of speaking out in the community and to policy makers to be activists in addressing health care disparities (Quotation 22).

Theme 4: approach to addressing health care disparities at the clinic level. Across the board, respondents believed that the PCMH model could contribute to reducing disparities, even by those unsure if the PCMH model should integrate a focus on health care disparities. Prioritizing health care disparities in clinic policy and implementation (eg, having specific attention and procedures to draw attention to health care disparities) were mentioned by almost everyone. (Quotations 23–27)

Grant makers, primary care practices, patient advocates, payers, policy makers, and practice transformation groups emphasized the importance of strengthening community partnerships and further integrating community groups within the clinical practice. Many noted the importance of sharing resources, acknowledging the limitations of primary care practices to meet all patients' needs. (Quotations 28–29)

Patient advocacy groups consistently called for further patient and family integration within primary care practices from the start of developing new interventions, rather than waiting until after policy or procedures are changed to get patient input. They also emphasized that primary care practices should be better aware of patient needs and give patients a stronger voice in the care delivery. The need for improved access for patients—including but also beyond insurance coverage—was noted as an important factor in reducing health care disparities, especially by grant makers, patient advocates, and payers. Patient advocates and grant makers included pearls of wisdom from their own experiences evaluating primary care practices, and the benefit of taking steps to make all patients feel welcome, such as incorporating culturally appropriate signs and decor in clinical practices.

Discussion

This qualitative analysis on the role of the PCMH in influencing health care disparities is the first, to the research team's knowledge, to incorporate this breadth of stakeholders, including patient advocates, primary care providers at non-PCMH clinics, and practice transformation organizations not specifically aligned with the PCMH model. Prior studies have discussed the potential value of integrating a focus on disparities into the PCMH model,^{14,15} and even engaged stakeholders involved in PCMH transformation,¹⁵ but this study goes one step further to include respondents with more varied perspectives on the PCMH's role in improving health care disparities, and more on-the-ground exposure. Having patient advocates and non-PCMH partnered participation is vital to understanding the implications and feasibility of adapting the PCMH model to address health care disparities, and contributed to the policy recommendations that follow.

Overall, there was extensive support for leveraging the PCMH model to reduce disparities, but with important qualifiers. At the crux of much of the discussion of how to integrate health care disparities into the PCMH model was whether more PCMH standards would be beneficial. Some argue that the value of the PCMH is less in the recognition process than in the availability of tools and funding to promote quality improvement.^{31,32} Creating a model of care that is applicable across a vast array of practice settings and populations is difficult. Although some interviewees questioned the benefits of PCMH accreditation or recognition, the attention to streamlining high-quality care and equipping clinics with the tools to transform are important. PCMH standards can be revised to include a specific focus on health care disparities and improve data collection to identify health care disparities within clinics, but this requires a commitment to identifying and explicitly targeting disparities, and not relying on benefits to trickle down to all patients. There is tension between more requirements and

allowing for flexibility so that clinics can decide what areas to focus on. Clinics need to be able to tailor standards to their patients' needs, but given the pervasiveness of disparities, there also should be some level of requirement to address health care disparities, and requirements need to be supported with the resources to achieve them, lest under-resourced clinics be left further behind.

Central to the discussion of addressing health care disparities is the role of addressing SDH. The impact of SDH on health care outcomes is widely accepted, but how and at what level the health care system should tackle SDH remains debated. It seems impossible to divorce addressing health care disparities from addressing SDH, and yet many clinics do not have the tools to adequately respond to patients' social and economic needs. The PCMH model can and should play a more active role in screening for and acting on SDH through multilevel interventions (eg, individual patient and community) to improve population health and reduce disparities in health care.

Two important takeaways from this study are that additional support, both at the clinic and policy levels, are needed to ensure meaningful progress, and that no individual measure holds the key to achieving equity in health care. Solutions must be multilevel, concerted efforts.

Following are 3 policy-level recommendations based on consideration of the stakeholder interviews:

1. *Enhance requirements for data collection to gather more comprehensive community- and clinic-level SDH and demographic information. Efforts must include further research into best methods to collect sensitive information on race, ethnicity, and language (REAL), and sexual orientation and gender identity (SO/GI).*

Reducing the preponderance of incomplete demographic data would be a first step in obtaining the relevant data that often has been noted as a prerequisite to address disparities in health and health care.^{2,15} At a basic level, the California Department of Health Care Services' Public Hospital Redesign and Incentives in Medi-Cal project includes an emphasis on more accurate and complete recording of REAL and SO/GI data,³³ recognizing this information as integral to improving health care access and value. Additional efforts are under way to determine how best to go beyond basic demographics and collect information on more specific SDH, such as through PRAPARE³⁴ (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences; the National Association of Community Health Centers' 22-question survey to screen for SDH, and the associated Toolkit to assist clinics in utilizing the survey) and Health Leads Reach³⁵ (Health Leads' Toolkit and electronic record to assist clinics in screening, tracking, and acting on SDH). The Center for Medicare and Medicaid Innovation launched the Accountable Health Communities initiative in the spring of 2018, aimed at evaluating the impact of social needs screening and interventions, for which they created a 10-item screening tool.³⁶ Blue Cross Blue Shield of Michigan's (BCBSM) PCMH program also includes specific provisions to collect demographic and SDH information for patient registries, with the stated aim of reducing disparities.³⁷ One cannot impact health care disparities without moving upstream to identify the SDH that are contributing to health care disparities, in addition to

internal health care system- and clinic-level policies that may cause and exacerbate disparities.

2. *Align reimbursement to explicitly incentivize addressing health care disparities, appropriately risk adjust caring for socially complex patients, and focus on value-based care to allow flexibility of using health care funds to address SDH.*

Many efforts are under way to advance alternative payment models; for example, Vermont's Blueprint for Health program, which is partnering with community organizations to address patients' SDH, and utilizes per-member-per-month and performance payments to incentivize high-quality health care.³⁸ The American Academy of Family Physicians has recently proposed an advanced primary care alternative payment model that endorses risk adjustment for SDH,³⁹ a model already being tested by MassHealth,⁴⁰ with a stated goal of ameliorating health care disparities. Aligning reimbursement with the realities of primary care practice efforts will better enable clinics to transform to meet the needs of their patients. As highlighted by respondents, having the resources and payment structure to deliver the necessary care and support to patients is vital. Clinics need to have the flexibility to fund ancillary care and allow team members to work to their full potential.

3. *Strengthen primary care–community integration. Provide funding and support to make culturally competent, linguistically congruent social and behavioral care and services more readily accessible to primary care settings.*

Already a part of many PCMH standards (though not required), providing culturally competent and linguistically congruent care is fundamental to reducing disparities and meeting the needs of vulnerable patients. Primary care–public health integration, the linkages between primary care, public health sectors, and social service providers, are necessary to better address patient needs outside of primary care (eg, SDH: transportation, financial health, child care, jobs, food security) given the impracticality of individual clinics housing comprehensive social services directly. Resources and reimbursement remain a focus of this recommendation, and community partnerships can help lessen the burden on individual clinics. BCBSM's PCMH program is one example of a PCMH working to strengthen community linkages, and to actively promote cultural and linguistic provider competencies.³⁷

Limitations

This study had several limitations. Although the researchers invited individuals with diverse perspectives, the views expressed by these individuals may not represent others who were not contacted or declined to participate. Secondly, the researchers did not interview patients directly, rather relying on patient advocacy organizations for their perspectives. Policy makers were another challenging group to recruit, with federal organizations noting inability to participate in research. Despite these limitations, this study provides new perspectives and insight on the ramifications and potential for integration of health care disparities into the PCMH model.

Conclusion

Over 10 years since the Joint Principles of the PCMH were first introduced, the PCMH model continues to be refined as more experiences of patients' and clinical care delivery settings emerge. This is an important moment to more directly position the PCMH model to address health care disparities. Although the philosophy behind the PCMH model lends itself to addressing health care disparities, this potential has not yet been fully realized by the accreditation process. Improving population health requires examination of current policies to ensure they are not contributing to disparities, and identifying and ameliorating those that already exist. This study highlights the importance of strengthening awareness of the communities served—their challenges and resources—and having the policy-level backing to incentivize going beyond basic medical services to address the upstream factors that affect patients' lives.

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Supplementary Material

Supplementary Data S1

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