

The Patient-Centered Medical Home: A Better Approach to Healthcare

What Is a Patient-Centered Medical Home?

A patient-centered medical home (PCMH) is an approach to providing comprehensive primary care for people of all ages and medical conditions. It is a way for a physician-led medical practice, chosen by the patient, to integrate health care services for that patient who confronts a complex and confusing health care system.

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a medical home as a central location for medical records of a child. In 2002, the AAP expanded their policy to include operational characteristics such as accessible, continuous, comprehensive, family-centered, coordinated, and compassionate care.

In February 2007, the AAP, American Academy of Family Physicians (AAFP), the American Osteopathic Association (AOA) and American College of Physicians (ACP) used this 40-year old concept to develop a set of joint principles that describe a new level of primary care which they call the Patient-Centered Medical Home. The Joint Principles for the PCMH can be summarized in these points:

- Ongoing relationship with a personal physician;
- Physician-directed medical practice;
- Whole-person orientation;
- Care is coordinated and/or integrated;
- Quality and safety;
- Enhanced access to care; and
- Payment appropriately recognizes the added value.

Why Is the Patient-Centered Medical Home Model Important?

The U.S. health care system currently produces poorer health outcomes at much greater costs than do the health systems of other industrialized nations. Payers and patients alike are looking for better value in health care and desire better quality at lower cost.

Does a Patient-Centered Medical Home Work?

Providers that have implemented patient-centered medical home principles have shown to:

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care.

These principles have been identified by the Institute for Healthcare Improvement (IHI) as the "Triple Aim." Information on pilots and demonstration projects across the country that have implemented PCMH can be found at www.pcpcc.net.

The Patient-Centered Medical Home

The patient-centered medical home (PCMH) is a model of health care delivery that is based upon an ongoing personal relationship with a physician. This personal patient/physician relationship provides continuous and comprehensive health care.

A medical practice that operates as a PCMH consists of the personal physician leading a team of health care professionals who collectively take responsibility for the ongoing care of the patient.

A whole person orientation is a key component of the PCMH. The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for managing care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end-of-life care. The patient actively participates in decision-making and provides feedback to ensure expectations are being met.

Care is coordinated across all elements of the patient's community including the health care system (hospitals, home health agencies, nursing homes, consultants and specialists), facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it.

Quality and safety are hallmarks of the patient-centered medical home. Evidence-based medicine and clinical decision-support tools guide decision making. Physicians in the practice accept accountability for continuous quality improvement. Information technology supports optimal patient care, performance measurement, patient education, and enhanced communication.

This enhanced access to health care means the practice provides patients with options such as open scheduling, expanded hours and various arrangements for communication between patients, the physician, the practice team and office staff.

How Are Physicians Compensated under the Patient-Centered Medical Home Model?

The PCMH appropriately recognizes the added value provided to patients who have a patient-centered medical home. In addition to current fee-for-service, the payment structure should:

- Reflect the value of patient-centered care management and coordination;
- Support adoption and use of health information technology;
- Share in savings and incentive payments for achieving measurable and continuous quality improvements.