



Patient Centered Medical Home

Highlights

DEFINING THE MEDICAL HOME AND ITS BENEFITS

The patient centered medical home model is the provision of comprehensive preventive and primary care which will improve health care quality and efficiency. The Robert Graham Center produced a white paper on the existing evidence for each of the seven core features of the patient centered medical home, including existing examples that best approximate it. The AAFP believes that the paper offers years of experience and research showing that the model, if widely adopted, can make the U.S. health care system perform better and deliver better health outcomes at lower costs.

The patient centered medical home generally has seven core features:

- Personal Physician
- Physician Directed Medical Practice
- Whole Person Orientation
- Coordination and Integration of Care
- Quality and Safety
- Enhanced Access
- Appropriate Payment

The concept delivers higher value not only to consumers but to the health care system as a whole.

Unlike the current U.S. system, which rewards high-volume, over-specialized and inefficient care, the patient centered medical home model is based on the premise that the best health care has a strong primary care foundation and with clear incentives for quality and efficiency. This model has been shown to improve the quality and cost-effectiveness of care for patients with chronic diseases, a huge cost-driver in our current system.

For an individual, the patient centered medical home model provides a regular source of primary care, which is associated with better health outcomes at lower cost. But the medical home model will also improve the patient experience. For example, patients enjoy enhanced access to care through open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

The medical home is characterized by:

- greater access to needed services
- better quality of care
- greater focus on prevention
- early identification and management of health problems

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EXPERIENCE AND RESEARCH DEMONSTRATING THE VALUE OF THE MEDICAL HOME

The research referenced demonstrates that having a regular source of preventive and primary care is associated with:

- lower per person costs
- lower emergency room utilization
- fewer hospital admissions
- fewer unnecessary tests and procedures
- less illness and injury
- higher patient satisfaction

Highlights of the studies in the report include:

- Ten years of experience at Group Health Cooperative of Puget Sound demonstrated the model can improve the quality and cost-effectiveness of care for patients with chronic diseases.
- A 2004 study by Katherine Baicker and Amitabh Chandra showed that states and counties with more primary care physicians show more efficient and effective use of care, leading to lower overall health care spending.
- North Carolina evaluated a multi-year effort employing a patient centered primary care approach with many elements of medical home model. An external accounting suggests that North Carolina Medicaid saved \$124 million over what it would have spent otherwise in 2006.
- Studies examining the experience in 18 wealthy Organization for Economic Cooperation and

Development countries document that a strong primary care system and practice characteristics such as patient registries, continuity, coordination, and community orientation were associated with improved population health.

- A comprehensive review of 40 studies published in the *Annals of Family Medicine* addressing the relationship between interpersonal continuity and care outcomes found that nearly 2/3rds of outcomes were significantly improved where patients had a strong and ongoing relationship with a primary care doctor.
- The Commonwealth Fund 2006 Health Care Quality Survey found that health care settings with features of a medical home—those that offer patients a regular source of care, enhanced access to physicians, and timely, well-organized care—have the potential to eliminate disparities in terms of access to quality care among racial and ethnic minorities.

To succeed, the patient centered medical home requires reform of the payment system. Fundamentally, it means restructuring the payment system so in addition to paying for procedures and treatment of acute conditions; physicians are compensated for health promotion, disease prevention and management. The current financial disincentives toward adequate primary care will have to be eliminated, and a new financing system that rewards continuity, patient-centered care and accountability will be needed if the patient-centered medical home is to be realized.

To read the complete report on the "Patient Centered Medical Home" model, please visit www.aafp.org/value.



**American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)**

**Joint Principles of the Patient-Centered Medical Home
February 2007**

Introduction

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

Principles

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is 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 in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care



- planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making
 - Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
 - Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
 - Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
 - Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
 - Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.



- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Background of the Medical Home Concept

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006).

For More Information:

American Academy of Family Physicians

<http://aafp.org/pcmh>

American Academy of Pediatrics:

http://aappolicy.aappublications.org/policy_statement/index.dtl#M

American College of Physicians

<http://www.acponline.org/advocacy/?hp>

American Osteopathic Association

<http://www.osteopathic.org>

