



Facts about the Patient-Centered Medical Home

The Patient-Centered Medical Home

The patient-centered medical home (PCMH) is a model of health care delivery that is based on 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. 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.

Care is coordinated across all elements of the patient's community including the health care system, 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. These outcomes are defined by a care planning process driven by a compassionate and robust partnership between the patient, the patient's primary physician, other physicians, health care providers and family members. The patient actively participates in decision-making and provides feedback to ensure expectations are being met.

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. 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.

Does a PCMH Work?

Community Care of North Carolina is a working example of a PCMH. The program shows excellent quality and cost outcomes through disease management, evidence-based clinical practice, and an emphasis on a physician-led team approach. Community Care of North Carolina is the state's Medicaid program. Two independent evaluations of this program indicate it has saved the state \$195 to \$215 million in 2003 and between \$230 and \$260 million in 2004 when compared to historical fee-for-service.

States and localities like Louisiana, Massachusetts, Minnesota and Washington, DC, are developing legislation to implement medical home pilot programs. Additionally, Section 204 of the federal Tax Relief and Health Care Act outlines a Medicare Medical Home Demonstration Project. This three-year project will involve care management reimbursement and incentive payments to physicians. It will evaluate the health and economic benefits of providing targeted, accessible, continuous, and coordinated, family-centered care to high-need populations.

A PCMH also addresses issues of health disparities. According to the new Commonwealth Fund report, [*Closing the*](#)

Divide: How Medical Homes Promote Equity in Health Care, when adults have health insurance coverage and a medical home, racial and ethnic disparities in access and quality tend to disappear. The analysis--based on a Fund survey of more than 2,830 adults nationwide--reveals that linking minority patients to a medical home can help them better manage chronic conditions and obtain critical preventive care.

The PCMH is gaining recognition among the private sector as well. UnitedHealthCare and IBM are working with the AAFP to implement medical home demonstration projects across the country.

In mid 2007, as a way to promote the revamping of the American health care system, several large employers joined with AARP and other consumer groups and with the four primary care physician organizations to organize the Patient-Centered Primary Care Collaborative. The goal of this group is to promote the PCMH as a most effective tool for improving health care quality for the patient and reducing costs for both the payers and the patients.

Recognizing a PCMH

Physician 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. The [National Committee on Quality Assurance](#), for example, has worked with the primary care physician groups to develop a [multi-tiered recognition process](#).

The [Patient-Centered Primary Care Collaborative](#) is working with the insurance industry and federal agencies and Congress to provide these recognized PCMH practices with appropriate compensation.

How Are Physicians Compensated Under the PCMH Model?

The PCMH appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should:

- Reflect the value of physician and non-physician staff work that falls outside of the face-to-face visit associated with patient-centered care management.
- Pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- Support adoption and use of health information technology for quality improvement.
- Support provision of enhanced communication access such as secure e-mail and telephone consultation.
- Recognize the value of physician work associated with remote monitoring of clinical data using technology.
- 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.)
- Recognize case mix differences in the patient population being treated within the practice.
- Allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- Allow for additional payments for achieving measurable and continuous quality improvements.

A focal point of the PCMH is that payment does not depend on expensive and time-consuming face-to-face visits. The team approach with online care and group visits create efficiencies that should lower the cost of care for most patients while affording physicians more time to provide the quality care their patients and payers deserve.

Why Is the PCMH 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. A recent report, [Financing the New Model of Family Medicine](#) (2004), estimates that if every American had a medical home, health care costs would likely decrease by 5.6 percent, resulting in national savings of \$67 billion dollars per year, with an improvement in the quality of the health care provided.