AMERICAN ACADEMY OF
FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

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

continued

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**.