What is the Patient-Centered Medical Home?

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- Health outcomes in the United States continue to fall behind those of other developed-and some less developed-countries, despite unrivaled spending.
- People, payers and physicians are looking for ways to improve care, improve value and transform practice

- The Patient Centered Medical Home, Robert Graham Center, November 2007

Cost of Chronic Illnesses

- More than 90 million American live with chronic illnesses
- Chronic diseases account for 70% of all deaths in the United States
- The medical care costs of people with chronic diseases account for more than 75% of the nation’s $1.4 trillion medical care costs.

AMA and the Medical Home

PCMH

- An approach to providing comprehensive care for all people of all ages and medical conditions
- American Academy of Pediatrics (AAP) introduced the medical home concept in1967
- In February 2007, the AAP, the American Academy of Family Physicians (AAFP), the American Osteopathic Association (AOA) and the American College of Physicians (ACP) used this 40 year old concept to develop a new set of joint principles that describes a new level of primary care

PCMH

- The PCHM is a model of health care delivery based on an ongoing relationship with a personal physician **trained** to provide first contact, continuous and comprehensive care

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

PCMH

- Whole Person Orientation

**The personal physician is responsible for providing for all the patient's health care needs or taking the responsibility for appropriately arranging care with other qualified professionals.*

**Inclusive of care for all stages of life; acute care; chronic care; preventive services; and end of life care*

PCMH

- Care is coordinated across all elements of the patient's community included in the healthcare system – hospitals, nursing homes, consultants etc.
- Quality and safety are hallmarks of the PCMH

  Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication

PCMH

- **Payment**

**should appropriately recognizes the added value provided to patients who have a patient-centered medical home*

**should pay for services associated for coordination of care both within and outside of office*

**should support adoption and use of health information technology for quality improvement*

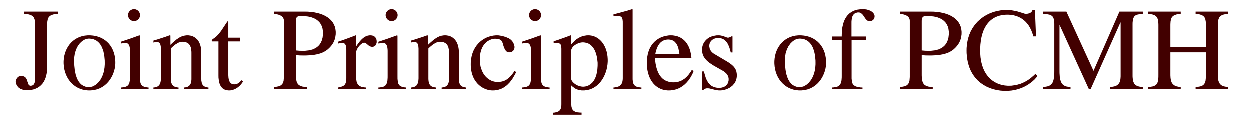
**should recognize case mix differences in the patient population being treated within the practice*

PCMH

- **Payment**

**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*



- Personal Physician
- Physician Directed Medical Practice
- Whole Person Orientation
- Care is Coordinated and/or Integrated
- Quality and Safety
- Enhanced Access
- Payment

Implications for Medical Education

- Creating innovative ways to recruit medical students to select primary care as a career choice
- Increase training time in primary care disciplines
- Improved training in the chronic disease management and prevention outcomes
- Improvement in developing curriculum around practice management
- A focus on teaching and learning in community settings

- Patients
- Physician practices
- Hospitals
- Local Medical Societies
- Medical Insures
- State Government and Agencies
- Community Organizations
- Pharmaceutical Companies

Collaboration

- Identify primary care physicians
- Optimizing common ground with specialists
- Evaluate office practices
- Offer products to help physicians prepare for the “New Model”
- Provide consultations around practice management
- Grant support