The Patient-Centered Medical Home: The Healthcare Delivery Model for the Future?

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One result of the Patient Protection and Affordable Care Act (PPACA) of 2010 has been a renewed conversation about the broken U.S. healthcare system. A wide range of proactive, strategic ideas and action steps have been suggested: alteration of the reimbursement mechanism, systemic efficiency improvements, emphasis on health and wellness promotion, programs that focus on improved outcomes, and methods to enhance adherence within the healthcare system. One potential method that received substantial attention in the PPACA is the organizational concept of the Patient-Centered Medical Home (PCMH), a transformational idea designed to improve quality of care while increasing systemic efficiency and reducing healthcare costs.

The PCMH is an innovative approach to providing comprehensive primary care. Dr. Robert J. Reid of Group Health Research Institute describes PCMH as an old-style family doctor's office, but with a whole team of professionals who work together to provide excellent patient care and outreach that helps patients stay healthy. PCHM teams combine modern medical knowledge with technology, including electronic medical records and email communication, for a unified, team-based approach to patient care. As an advocate of PCMH, the American Academy of Family Physicians argues, "Unlike the current United States healthcare system, which rewards high-volume, over-specialized, inefficient care, the PCMH is based on the premise that the best healthcare has a strong primary care foundation with clear incentives for quality and efficiency. This model has been shown to improve quality and cost effectiveness of care for patients with chronic diseases, a huge cost-driver in our current system."

While the concept is not new, its viability as a workable solution has resulted in increasing support from the medical community. In 1967, the American Academy of Pediatrics (AAP) introduced the concept of a central location for a child's medical records, which can be especially important when caring for children with unique health care conditions. From there, the concept evolved to a comprehensive method of providing all-inclusive primary care for both children and adults at the community level. By 2007, the American College of Physicians (ACP), American Academy of Family Physicians (AAFP), and American Osteopathic Association (AOA) had joined forces with AAP.

In response to a group of large employers in search of creative ways to improve efficiency and effectiveness in their healthcare delivery systems, the above medical associations, representing 333,000 physicians, worked together to formulate the PCMH core attributes and subsequently issued the Joint Principles of the Patient-Centered Medical Home.

For a brief Summary of the principle included please see fig 1.

With these principles as a foundation, the PCMH concept continues to evolve as a healthcare delivery model in many communities. Over 38 pilot programs were funded across the country by June 2010, with promising results for both quality of patient care and systemic efficiencies.

Patients participating in a PCMH model receive a centralized, regular source of primary care, which has been associated with better health outcomes. The medical model also improves the patient experience through greater access to services, better quality care, a focus on prevention, and early identification and management of health problems.

Studies indicate that the PCMH model is also successful in reducing healthcare costs and improving systemic efficiencies. In 2009, Group Health Cooperative's one-year PCMH study revealed that emergency room visits decreased by 29%, the rate of hospitalization dropped by 11%, and in-person visits declined by 6%. Additionally, physicians and staff reported a reduction in "burnout" due to the use of new forms of communication, including mobile phones and e-mails.

Vermont's Blueprint for Health pilot study, launched in July 2008, also reported initial positive results in October 2010: inpatient use decreased 21%, with per person/per month costs reduced by 22% and

emergency room use decreased by 31%, with per person/per month costs reduced by 36%.

The success of these studies, as well as others around the country, provides encouraging "proof-of-concept" results for ongoing development of the PCMH. While the clinical and economic potential of the PCMH is promising, it is a work in progress and an optimal design has yet to be identified. The PCMH of the future will be a fine-tuned variation of the pilot programs currently underway.

The perfect storm of increasing health costs combined with an aging and unhealthy population contributes to the pressing need to transform our health care system. The 2010 healthcare reform legislation has served as an accelerant for examination of viable alternative models and the Patient-Centered Medical Home may prove to be one of the best models for the future of American healthcare.

Fig 1. Summary of Principles

Principle	Description
Personal Physician	Patients are assigned to a personal physician who provides first contact, continuous and comprehensive care.
Physician-Directed Medical Practice	Personal Physician leads all other health care providers in the patient's care.
"Whole Person" Orientation	Personal physician is responsible for all of the patient's care, including acute, chronic, preventative and end-of-life care.
Integrated and Coordinated Care	Care is coordinated across all facilities through healthcare technology, assuring care is provided when and where it is needed and in a culturally and linguistically appropriate manner.
Quality and Safety	Quality and safety identified as hallmarks of PCMH: • Practice collaborates with patient and family to define a patient-centered care plan. • Practice uses evidence-based medicine and care pathways. • Practice performs continuous quality improvement by measuring and reporting performance metrics. • Patient feedback is incorporated into performance measurements. • Patients and families participate in practice quality improvement. • Information technology is a foundation of patient care, performance measurements, communication and patient education. • Practices are certified as patient centered by non-governmental entities.
Enhanced Access to Care	Patients can take advantage of open scheduling expanded hours and new communication options with the physician practice.
Payment	Payment should recognize added value of PCMH plan. • Payments reflect physician and non-physician value and encompass payments for all services, including non-face visits and care management. • Practices share in savings from reduced hospitalizations. • Physicians receive bonus payments for attaining predetermined quality metrics.