Scientific Underpinning

of

Preventive Medicine Associates Inc.

Medical Home Model

What is a Medical Home Model?

The **medical home,** also known as the **patient-centered medical home** (PCMH), is defined as "an approach to providing comprehensive primary care... that facilitates partnerships between individual patients, and their personal providers, and when appropriate, the patient's family." The provision of medical homes may allow better access to health care, increase satisfaction with care, and improve health.

The concept of the medical home has evolved since its introduction at the American Academy of Pediatrics in 1967. In 1992 the Academy published a policy statement defining a medical home, and in 2002 they expanded and operationalized the definition.

In 2002, seven U.S. national family medicine organization created the *Future of Family Medicine* project to "transform and renew the specialty of family medicine." Among the recommendations of the project was that every American should have a "personal medical home" through which to receive his or her acute, chronic, and preventive services. The services should be "accessible, accountable, comprehensive, integrated, patient-centered, safe, scientifically valid, and satisfying to both patients and their physicians."

American College of Physicians has developed an "advanced medical home" model. The model involves the use of evidence-based medicine, clinical decision support tools, the Chronic Care Model, medical care plans, "enhanced and convenient" access to care, quantitative indicators of quality, health information technology, and feedback or performance.

n 2007 the largest primary care physician organizations in the United States released the *Joint Principles of the Patient-Centered Medical Home.* The principles listed were:

- **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."
- **Care is coordinated and/or integrated,** for example across specialists, hospitals, home health agencies, and nursing homes.
- **Quality and safety** are assured by a care planning process, evidence-based medicine, clinical decision-support tools, performance measurement, active participation of patients in decision-making information technology, a voluntary recognition process, quality improvement activities, and other measures.
- **Enhanced access** to care is available {e.g., via "open scheduling, expanded hours and new options for communication"}.
- **Payment** must "appropriately recognize[s] the added value provided to patients who have a patient-centered medical home." For instance, payment should reflect the value of "work that falls outside of the face-to-face visit," should "support adoption and use of health information technology for quality improvement," and should "recognize case mix Scientific evidence.

Recent peer-reviewed literature that examines the prevalence and effectiveness of medical homes ncludes:

- In 2007, researchers from the Centers for Disease Control and Prevention published a study involving interviews with 5400 parents; the authors concludes that continuous primary care in a medical home was associated with higher rates of vaccinations for the respondents' children.
- Schoen and colleagues (2007) surveyed adults in seven countries, using the answers to four questions to categorize the respondents as having a medical home or not. Having a medical home was associated with less difficulty accessing care after hours, improved flow of information across providers, a positive opinion about health care, fewer duplicate tests, and lower rates of medical errors.
- A review of 33 articles by Homer et al. on medical homes for children with special health care needs published in 2008 "provider[d] moderate support for the hypothesis that medical homes provide improved health-related outcomes."
- A 2008 review by Rosenthal determined that peer-reviewed studies show "improved quality, reduced errors, and increased satisfaction when patients identify with a primary care medical home."
- In a survey of parents or legal guardians of children with special health care needs published is 2009, 47.1% of the children had a medical home, and the children with a medical home had "less delayed or forgone care and significantly fewer unmet needs for health care and family support services" that the children without a medical home.
- Reid et al. (2010) showed within the Group Health system in Seattle that a medical home demonstration was associated with 29% fewer emergency visits, 6% fewer hospitalizations, and total savings of $10.30 per patient per month over a twenty-one month period.

Wikipedia. (2010). Medical Home Model. Retrieved on December 29, 2010. http://en.wikipendia.org/wiki/Medical_home