What is a Medical Home?

The Medical Home, also called the Patient-Centered Medical Home, and the Personal Medical Home, is a movement to solve the problem of fragmented care (one hand doesn't know what the other is doing) by having a primary care physician or practitioner act as the center of all care information for the patient. Fragmented care is dangerous (lack of coordination of care causes mistakes and mistreatments), costly (repetition of diagnostic tests and regimens), and wasteful of healthcare resources. The Medical Home plan goals are to provide care for all individuals, improve care, and decrease healthcare costs.

"**Crossing the Quality Chasm: A New Health System for the 21st Century**" was published in 2001 by the Institute of Medicine. In this landmark book, the patient's role and responsibility for navigating the healthcare system and acting as the information hub around which the spokes of primary, specialty and tertiary care providers revolve was denounced as unreasonable and detrimental. Since 2001 the concept of the Medical Home, a focal point through which all patients receive acute, chronic and preventive medical services, has been the object of a number of pilot projects, most notably the CIGNA/Dartmouth-Hitchcock pilot project announced last summer, a Blue Cross Blue Shield of Michigan project announced yesterday and the CMS Demonstration Projects. To access more information on the CMS Medical Home demonstration projects, including an email notification signup, **click here**.

On April 14, 2009, new White House Health Reform Director Nancy-Ann DeParle stated "There are very robust demonstrations of (the medical home) going on right now in the private sector. Some insurance companies are doing this already, and they have shown real promise. We hope to move forward with (the program) in Medicare." DeParle also said "We want to move toward things that will bend the (cost) curve to create

better incentives for physicians and hospitals to treat patients in a smarter way.”

An exerpt from Wikipedia describes the seven characteristics of the Patient-Centered Medical Home, as determined by the **American Academy of Family Physicians**, the **American Academy of Pediatrics**, the **American College of Physicians**, and the **American Osteopathic Association** in 2007:

- **Personal Relationship:** Each Patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- **Team Approach:** The Personal Physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing patient care.
- **Comprehensive:** The personal physician is responsible for providing for all the patient’s health care needs at all stages of life or taking responsibility for appropriately arranging care with other qualified professionals.
- **Coordination:** Care is coordinated and integrated across all domains of the health care system, facilitated by registries, information technology, health information exchange and other means to assure that patienst get the indicated care when and where they want it.
- **Quality and Safety:** Quality and Safety are hallmarks of the medical home. This includes using electronic medical records and technology to provide decision-support for evidence-based treatment and patient and physician involvement in continuous quality improvement.
- **Expanded Access:** Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, physicians, and practice staff.
- **Added Value:** Payment that appropriately recognizes the added value provided to patients who have a Patient-

Centered Medical Home.