Patient-Centered Medical Home:

Overview and Barriers to the Theory
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INTRODUCTION

The US healthcare system is unsustainable over the long term and thus is in need of a seismic overhaul.\textsuperscript{1,2} The healthcare crisis is projected to continue for some time, even with the implementation of new models that address current problems and attempt to foresee future issues: increasing costs without corresponding improved outcomes, an aging population with chronic health problems, and a shortage of primary care physicians (PCPs).

Research by the American College of Physicians (ACP) indicates that the United States ranks highest in average spending and in spending as a percentage of the gross domestic product (GDP) compared with other developed countries worldwide, yet ranks lowest in both primary care functions and patient outcomes. According to The Commonwealth Fund, an independent healthcare research organization, costs continue to increase. Healthcare spending was 16\% of the GDP in 2006 and is projected to increase to 20\% by 2016.\textsuperscript{3} Despite the high rate of spending, the quality of US healthcare is variable, access is inequitable, and inefficiency is widespread.

Compounding the problems in US healthcare are the increasing number of older patients with chronic illnesses and the increasing longevity of these patients.\textsuperscript{4} An estimated 75\% of the rise in healthcare spending since 2000 has been attributed to chronic diseases, which are more prevalent in older persons.\textsuperscript{1} By 2025, an estimated 25\% of all Americans will have 2 or more preventable chronic conditions. By 2030, 20\% of the population will be older than 65 years of age.\textsuperscript{5} Patients with chronic illnesses require additional efforts by PCPs to coordinate their healthcare, which may be provided by one or more specialists for each condition.

These many challenges are indicative of the urgent need for reform of the US healthcare system. The Commonwealth Fund report suggests that it is possible to improve healthcare access and quality as well as the health of the population while reducing overall spending by implementing all of the following policies as a group:\textsuperscript{3}

- Production and use of better information for healthcare decision making
- Promotion of health and enhancement of efforts to prevent disease
- Alignment of financial incentives with health quality and efficiency
- Correction of price signals in healthcare markets

Stakeholders agree that the major goal of reform is to transform the current healthcare system into one with improved patient care and increased affordability. Expert policymakers agree that the emphasis should be on reform through both preventive care and the management of preexisting chronic conditions, especially by PCPs.\textsuperscript{1}
An innovative solution is the Patient-Centered Medical Home (PCMH) model, which promotes a fundamental change in the way in which primary care is delivered and financed. The main objective of this model is to transform a fragmented healthcare system that is oriented toward illness, which supplies acute care episodically, into one that is patient-centered, which will provide coordinated care across all stages of life. The PCMH model (ie, the “medical home”) is composed of a central resource with a physician specialist and a competent team to provide the management and coordination of continuous and complex care to informed, involved patients (see the section on History of the Medical Home). The PCP is at the center of this model.2

This white paper reviews the need for major change in the US healthcare system, the concept of the PCMH, and barriers to the successful large-scale adoption of this far-reaching, much-needed option for healthcare reform.

Methods

Numerous research and journal articles written between 2005 and 2010 were reviewed, along with statements and position papers. Search terms used were “medical home” AND “patient-centered.”

NEED FOR A CHANGE

Expanding the role of PCPs may optimize the healthcare dollar. Research by the ACP indicates that US states with high ratios of PCPs compared with other states have better health outcomes, such as decreased mortality rates from cancer, heart disease, and stroke.5 Thus, PCPs may be best equipped for the coordination of care and the prevention and management of chronic diseases. The PCP would be well placed to perform the role of coordinator. However, because coordination of care has not been a typical feature of PCP practice, PCPs may lack the resources, infrastructure, and funding to carry it out. In addition, the demand for PCPs has been increasing and the supply decreasing. From 1997 to 2005, the number of medical graduates accepting residencies in primary care decreased by 50%.6

HISTORY OF THE MEDICAL HOME

The concept of the medical home was originally reported on in the 1960s in the pediatric literature as a way to utilize the primary care practice as the central repository of care for and clinical data on patients.7,8 Spurred by the Health Maintenance Organization Act signed into law by Richard Nixon in 1973, managed care organizations (MCOs) were introduced as a way to provide better care and
manage costs. The key to the MCO concept, which is still a predominant force today, was to create primary care “gatekeepers” to decrease expensive visits to specialists. However, as a poll in 2004 by the Kaiser Family Foundation discovered, backlash occurred because consumers believe that their for-profit nature has led MCOs to be more interested in “managing” costs and less interested in patient care. At the same time, PCPs are frustrated and disillusioned with their new role as administrative gatekeepers that often seems to them to have supplanted or “squeezed out” their preferred role as conduits of quality care.

In 2002, seven national family medicine organizations initiated the Future of Family Medicine project to “transform and renew... family medicine to meet the needs of people and society in a changing environment.” The results of the project were published in 2004, at a time when the medical home concept was at the forefront of the recommendations. In 2006, the ACP provided additional support for this concept by releasing a policy paper entitled “The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care.” The ACP called for fundamental changes in care and third-party reimbursement for practices that qualify as advanced medical homes.

Ultimately, most researchers agree that the United States needs to move to a system in which the role of the PCP changes from gatekeeper to coordinator of care. The goals are to improve quality and decrease overall costs. Over the last few years, many primary care associations have developed individual position statements regarding the need for a fundamental change in the way that primary care is delivered and financed, embedding the medical home concept as a model.

In 2007, four primary care associations, representing 333,000 physicians, convened to develop a consensus opinion on the subject. This cohesive effort to describe the characteristics of the PCMH culminated in the Joint Principles of the Patient-Centered Medical Home (2007), representing the ACP, American Academy of Family Physicians (AAFP), American Academy of Pediatrics, and American Osteopathic Association.

In 2008, an article in The New England Journal of Medicine in 2008 indicated that expectations are high for the medical home concept. “States, health plans, and the Medicare program are making substantial financial bets that implementation of the medical home will lead not only to improved care but also to long-term savings, largely by reducing the number of avoidable emergency room visits and hospitalizations for patients with serious chronic illness.”
THE PATIENT-CENTERED MEDICAL HOME

The PCMH model redesigns the way primary care is delivered and financed. At the core of the PCMH is coordinated care delivered by a PCP who accepts responsibility for the “whole person” and acts in partnership with patients and in collaboration with multidisciplinary teams consisting of, for example, nurses, physician specialists, health educators, and pharmacists. The PCMH focuses on hallmarks of the medical home—patient safety and patient outcomes—and uses technology systems to improve communication and access to and integration of care. Making significant steps toward a system that is more responsive to the needs of patients, the practice accepts responsibility for care provided based on ongoing performance measurements to attain quality improvement.16

Although the concept of the medical home is fairly clear in its vision, time will tell which core characteristics will yield the best results for both patients and the healthcare system overall. The Joint Principles spell out seven core elements, on which most of the research surrounding medical homes expands to some degree16:

1. **Personal physician:** Each patient has an ongoing relationship with a trained physician who provides comprehensive care.
2. **Physician-directed medical practice:** A team of practitioners is led by a personal physician, and all are collectively responsible for the patient.
3. **Whole-person orientation:** All patient healthcare needs are coordinated through the personal physician and the provider team at the practice level. Care and preventive services are provided across acute and long-term needs and at the end of life. When services cannot be provided at the practice level, the personal physician and team arrange care with other qualified professionals, including specialists.
4. **Coordinated and/or integrated care:** Coordination exists across all elements of the complex healthcare system.
5. **Quality and safety:** Practices advocate for patients through strong partnerships; decision making is guided by evidence-based medicine and decision support systems; physicians voluntarily engage in performance measurement and quality improvement; patients provide feedback and are active participants in their care; healthcare information technology (HIT) is used for performance measurement, patient education, and enhancement of communication; and physicians voluntarily submit to a governmental recognition process.
6. **Enhanced access to care:** Systems at the practice level allow for enhanced access to the practice, and services include open scheduling, expanded hours, and better access to communication for patients.
7. **Payment:** There is tremendous added value to the patient, which will be reflected in the payment/reimbursement system for the PCMH practice.
The Patient-Centered Primary Care Collaborative (PCPCC), the National Committee for Quality Assurance (NCQA) standards and criteria, and The Commonwealth Fund are the predominant leaders for provider recognition. The PCPCC was formed in 2005 by individual entities that were interested stakeholders in reforming the delivery of care, and the organization remains one of the major developers and advocates of the PCMH. The membership includes national employers, most major PCP associations, health benefits companies, trade associations, professional affinity groups, academic centers, and healthcare quality improvement associations, all of which work to implement medical homes nationwide. The original objective of the PCPCC was to reach out to PCP groups to improve physician-to-patient relationships and create a more efficient, effective healthcare delivery system.\textsuperscript{17} The NCQA, a PCPCC member, adopted specific PCPCC criteria and additional optional elements that a practice must implement to achieve recognition as a medical home. These criteria are purposely aligned with the Joint Principles and monitored under the Physician Practice Connections—Patient Centered Medical Home (PPC-PCMH) of the NCQA, which lists 9 standards:\textsuperscript{18}

<table>
<thead>
<tr>
<th>Standard</th>
<th>Content</th>
<th>Total Points</th>
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<tr>
<td>Standard 1</td>
<td>Access and communication</td>
<td>9</td>
</tr>
<tr>
<td>Standard 2</td>
<td>Patient tracking and registry functions</td>
<td>21</td>
</tr>
<tr>
<td>Standard 3</td>
<td>Care management</td>
<td>20</td>
</tr>
<tr>
<td>Standard 4</td>
<td>Patient self-management support</td>
<td>6</td>
</tr>
<tr>
<td>Standard 5</td>
<td>Electronic prescribing</td>
<td>8</td>
</tr>
<tr>
<td>Standard 6</td>
<td>Test tracking</td>
<td>13</td>
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<tr>
<td>Standard 7</td>
<td>Referral tracking</td>
<td>4</td>
</tr>
<tr>
<td>Standard 8</td>
<td>Performance reporting and improvement</td>
<td>15</td>
</tr>
<tr>
<td>Standard 9</td>
<td>Advanced electronic communicators</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>100</strong></td>
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These 9 standards can result in one of three levels of recognition as a PCMH. Based on the numerical ratings (total number of points) assigned to these standards, practices need to reach a minimum score of 25 of 100 points to obtain recognition as achieving one of the three levels. Practices must also pass at least five of the following 10 criteria:\textsuperscript{18}
Ten Criteria

1. Written standards for patient access and communication
2. Use of data to show that standards for patient access and communication are met
3. Use of paper or electronic charting tools to organize clinical information
4. Use of data to identify important diagnoses and conditions in practice
5. Adoption and implementation of evidence-based guidelines for three chronic conditions
6. Active patient self-management support
7. Systematic tracking of test results and identification of abnormal results
8. Referral tracking, using a paper or an electronic system
9. Clinical and/or service performance measurement
10. Performance reporting

PPC-PCMH scoring is as follows:

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<th>Level</th>
<th>Points</th>
<th>“Must Pass”</th>
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<tr>
<td>3 (highest)</td>
<td>75-100</td>
<td>10 of 10</td>
</tr>
<tr>
<td>2</td>
<td>50-74</td>
<td>10 of 10</td>
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<tr>
<td>1</td>
<td>25-49</td>
<td>5 of 10</td>
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* At 50% performance level.

Practices with less than five “must pass” elements or a numerical score of 0 to 24 points do not qualify to be recognized as a PCMH.

The PCPCC convenes and supports demonstration projects and pilot programs through the Center for Multi-Stakeholder Demonstrations. In 2012, a total of 48 pilot projects are being implemented in 26 states, with more than 19,000 physicians.19

The Commonwealth Fund is an independent foundation that supports independent research on healthcare issues that advance its mission to “promote a high performing healthcare system that achieves better access, improved quality, and greater efficiency.”17 Similar to the NCQA, The Commonwealth Fund has played a leadership role in the development and implementation of the PCMH. The models of recognition of The Commonwealth Fund and the NCQA also differ. The Commonwealth Fund focuses on outcome endpoints; the NCQA principles are
more process oriented and less demanding. For example, The Commonwealth Fund has standards such as “I have no difficulty contacting my provider by telephone;” whereas NCQA criteria are more open-ended, for example, establishing that providers need to show that they have standards for enhanced access to care.

In June 2009, the AAFP launched a section on its website dedicated to the PCMH in order to assist physicians in making the transition in their practices. Four main sections focus on:  
1. Organization of the practice  
2. Health information technology (HIT)  
3. Quality measures and ways to enhance the quality of delivery  
4. Patient-centered care, for physicians dedicated to including patients in the decision-making process

In theory, the PCMH appears to be an innovative solution to part of the healthcare dilemma—better quality care and a closer monitoring of healthcare usage, which can decrease costs overall. However, the potential for major progress carries with it barriers to overcome.

BARRIERS TO THE THEORY OF THE PATIENT-CENTERED MEDICAL HOME

 Barrier One: Shortage of Primary Care Physicians

The medical home concept depends highly on an adequate supply of trained PCPs in the United States. Currently, PCPs are greatly overburdened with:

- High patient loads
- Increasing numbers of patients with chronic conditions
- Reimbursement issues
- Escalating costs of providing quality healthcare
- High medical malpractice premiums
- Administrative duties

Recent healthcare reform will only add to this burden, when millions of previously uninsured Americans will have healthcare insurance and thus greater access to PCPs. A wide income gap exists between PCPs and specialists. To make matters worse, fewer medical students are interested in becoming PCPs and practicing PCPs are retiring early.
Possible Solutions

The PCMH has various ways to help alleviate some of the issues inherent in initiating and maintaining a career in primary care: enhanced office systems and assistance, enhanced patient relationships, support in adopting HIT, and a proposed overhaul of reimbursement methods that recognizes the added value of delivering care. A concerted effort to graduate and train more PCPs is an urgent and critical issue at the forefront of all key objectives of the major primary care associations. However, few data show that these changes will alleviate the burden on PCPs or lead more physicians to choose this career path. It also is unlikely that the PCP shortage will improve in the short term because of the temporal element.

Barrier Two: Physician Practice Infrastructure and Coordination of Care

Some of the most ambitious goals of the PCMH guidelines require PCPs to provide for very aggressive recommendations: open access for patients (eg, in the way of same-day appointments); and open access to clinical information, both within the practice and from outside healthcare providers (eg, physician specialist offices, nursing homes, hospitals, laboratories, and pharmacies). To implement open access, new PCMH offices will need to add expensive technology, overhaul the practice completely, and work through a backlog of patients, all of which can take months and require additional staff in the short term. Recognizing that the current US healthcare communication system is highly fragmented across the continuum of care makes integration a goal that may take years to achieve.

Possible Solutions

A complete shift in the infrastructure of the primary care office will be required. PCPs will need to lead a care coordination team that is thoroughly involved in each patient case, compared with the current structure that has the PCP at the head of the office with various support staff. At a practice level, a team approach can provide better care by directing patients to the most appropriate level of service. For most medical practices, this is not an easy shift. Success of this process will depend highly on a defined reward system that provides an incentive for the integration and coordination of all medical records and information sharing to facilitate collaboration between all parties involved in patient care.

Barrier Three: Healthcare Information Technology

Coordination of care in the PCMH is heavily reliant on the ability of practices to enhance their HIT, in order to both facilitate better care for the patient and provide payers with a way to understand reimbursement, best practices, health outcomes, and costs. HIT may vary in complexity from simple patient registries
with descriptions of interactions with patients to integrated systems of data storage and evidence-based decision support tools. However, providers highlight high costs and inadequate reimbursement as major barriers to rapid implementation of HIT. Because the evidence is limited as to which areas of HIT are most beneficial, a challenge remains in widespread adoption. For PCPs, the question remains as to whether HIT will actually be helpful in managing the administrative work that overburdens typical practices.

Possible Solutions

The key is for practices to catch up to the efficiency produced by technology in terms of information exchange. With the click of a button in the HIT system, a specialist should be able to copy PCPs on the specialist’s evaluation. In turn, PCPs should be able to easily access templates and algorithms to assist in managing patients with chronic illnesses by finding the correct medication and calculating the appropriate dosage based on easily accessible laboratory results. HIT should also tackle the complex problem of unifying the external, highly fragmented US system. One primary goal of the PCMH is coordinating care, and it can be accomplished only if the transference of records can be done easily over multiple sites of care. If the PCMH can streamline the administrative burden, rather than add to it, then more primary care offices may be in line to become PCMHs. Primary care practices also must be reimbursed for their efforts to meet all of the technology criteria.

Barrier Four: Reimbursement for Primary Care Physicians

Arguably, reimbursement is the central barrier to be addressed for the PCMH to become a success. To the PCP who is already overburdened, the added attributes of the PCMH may seem out of reach. The inclusion of outcome measurements may further intensify the frustration of PCPs. There must not be the perception that the PCMH will add yet another layer of problems and bureaucracy. Any discussion regarding reimbursement related to the PCMH model also leads to the looming question of who will pay for the PCMH. It is far from clear how spending more on medical homes will lead to lower total spending. Supporters of the medical home model should not underestimate the long-term commitment of payers that will be required to successfully implement an adequate reimbursement structure.

Possible Solutions

The financial reimbursement issue must be tackled head on. A reimbursement model that adequately incentivizes physicians to effectively prevent and manage chronic illnesses is the linchpin of the PCMH, meaning that physicians must be reimbursed for non-reimbursable services typically provided at a loss to the
practice (eg, e-mail visits, reminders, patient access to medical records, and physician coordination with specialists and hospitals). Most stakeholders agree that the system should include a blended per-patient fee and a fee-for-service system. Some believe that a monthly medical home fee instead of a per-patient fee would be sufficient to address nonreimbursable services and help to offset the increased costs to practices for items such as HIT and the time of personnel and physicians. The PCPCC also recommends a hybrid model and higher payments to physicians based on achieving better outcomes and reducing total healthcare dollars spent. These payments should:

1. Incentivize physicians to adopt and utilize HIT systems
2. Recognize the additional time necessary to deliver care through a medical home
3. Be sufficient to address long-standing payment inequities that undervalue primary care
4. Include rewards based on performance

The PCPCC suggests a three-part reimbursement model that includes a monthly care coordination payment, a face-to-face visit component, and a component based on performance that recognizes achievement of quality and efficiency goals. Proponents suggest that government investments in the short term will reap long-term rewards by ultimately lowering overall costs; however, this remains theory only.

DEMONSTRATION PROJECTS

The Commonwealth Fund is supporting several medical home demonstrations, and preliminary data are encouraging. A pilot project at The Geisinger Health System in Pennsylvania has shown a 20% reduction in admissions and a 12% decrease in readmissions at one of its hospitals. All of the clinicians in the Geisinger Health System are connected through fully integrated HIT, and patient care has been expanded to include ongoing telephone monitoring, telephone follow up after hospital and emergency department discharge, access to clinicians by telephone, health education services, and support for chronic diseases. Geisinger does not serve a high proportion of elderly patients or patients on Medicaid. However, a demonstration at the North Carolina Medicaid program, called Community Care of North Carolina, is also showing promise. An independent analysis found that an initial investment of $10.2 million resulted in savings of $225 million when it compared enhanced fees to manage and coordinate patient care with traditional fee-for-service payment.
CONCLUSIONS AND FUTURE CONSIDERATIONS

The PCMH is expanding on elements of managed care, building bridges to provide quality patient care and meet patient needs. The PCMH represents a fundamental shift in US healthcare, and preliminary data are promising. It will be important to learn from the ongoing demonstration projects and initial attempts at transformation of primary care, and to recognize that the timeline for success needs to be realistic and achievable.

Most experts fundamentally believe that improved coordination of care and more effective management of disease will result in better quality of care and lower utilization rates among patients in medical homes. However, it is highly unclear whether these savings will more than offset the increased payments to those medical homes.

Despite the support that the PCMH has received from major stakeholders, data supporting this concept are still in the early stages and little has been translated into actionable steps. The patient experience, in theory, would seem to be improved with this concept; however, the reduction of costs appears to be more unattainable owing to the costs necessary to incentivize and reimburse practices. This problem may be solved in the long term as PCMH offices become more adept at managing patients with chronic illnesses and more focused on the prevention of chronic illnesses.

Any additional temporal or administrative burdens that the PCMH potentially places on PCPs would prove to be detrimental to an already overburdened physician group. The key medical home services and infrastructure are reimbursed inadequately or not at all in the current reimbursement structure, which rewards procedures and not cognitive services. PCPs will need to see real benefits individually as well as to their practices. Therefore, to obtain solid traction, the PCMH concept must secure adequate capital funding from multiple sources such as federal, state, and local governments, as well as from healthcare insurance companies. Asking PCPs to convert to the PCMH model only with the hope of securing more adequate funding in the future is unlikely to succeed.

Although the need for the PCMH model is clearly defined and agreed on, an enormous amount of work is still to be done to advance this concept in terms of evidence-based data. The sense of urgency to have rapid adoption of the PCMH is understandable; however, PCMH stakeholders will be affected by how these abstract concepts are defined. Expectations that are too high will be a threat to the concept. For example, the PCMH is not a cure-all for the increasing costs of healthcare. It would be detrimental if the concept were abandoned because results were not immediate or costs were to escalate in the short term.
Beyond the framework of the Joint Principles, there are few answers. As the concept progresses, providers will need specific direction for redesigning their practices, payers will need specific criteria for reimbursement, and policymakers will need concrete endpoints to evaluate success or failure of medical homes. Although many demonstration projects are occurring across the United States, evidence is still forthcoming to show that the implementation of these guidelines will improve patient care or decrease costs.

Importantly, the PCMH concept will need to expand its reach beyond the practice level to specialists, hospitals, nursing homes, and other specific points of care. A system of accountability will need to be implemented to determine who in the healthcare system is responsible for making the final decision on care.

- Will patients demand to see a specialist, even though it is not suggested by the PCMH?
- Will specialists refuse to work with some PCMHs over others?
- If the insurance company makes the final call, then will we be back to the MCO model of managing costs?

Because medical home criteria are focused on the primary care office, the medical home has little leverage to force specialists and other healthcare sites to curtail spending and coordinate care. To the extent that specialists continue to be financially rewarded for service volume, it is unlikely that they will be active participants in the medical home concept if it affects their annual income. Therefore, reform objectives for the primary care office must be aligned with reform across all providers to promote shared accountability for coordination of care and overall cost reduction. For success, the interests of all physicians and hospitals must be aligned with other efforts of reform toward the improvement of patient care.

Many researchers are attempting to determine whether the PCMH will achieve better and less expensive outcomes than today’s traditional means of care. Governmental agencies, public and private organizations, insurance companies, and other associations and organizations are conducting ongoing studies to answer this question. If the results are positive, they could be the basis of a national model for the improvement of health delivery and a transformation of the way that healthcare is delivered.

In an effort to make this concept a reality, the nomenclature of the PCMH will need to be addressed and standardized. While researching this paper, the concept of PCMH was described as the “medical home,” and the “advanced medical home.” Even the acronyms for the “patient-centered medical home” were not consistent: PCMH versus PC-MH. Without a “brand” for the concept, the effort will most likely be diluted and lose its power. Indeed, the name itself may need to be fully tested because some consumers are turned off by the term “medical home,”
owing to the negative connotations of inpatient care at nursing homes and mental health facilities. In contrast, to some consumers the PCMH can be interpreted as physicians who make house calls.

Another open question is the idea of oversight. Some believe that oversight is essential to the success of the PCMH. The Joint Principles ask that a nongovernmental agency be responsible for the training on, education about, and support of the PCMH. Although the NCQA has taken the lead on the recognition process, it is unclear whether the NCQA is equipped to be the oversight group.

Although it leaves many questions unanswered, the PCMH model can surely be a part of the overall solution to the looming shortage of PCPs and the need for more integrated care. Logically, at a time when the current Administration has passed legislation that includes healthcare insurance coverage for millions more Americans, the PCMH is certainly a direction that needs to be rapidly studied and explored. Unless the critical barriers are addressed, pushing the system to accept the PCMH too quickly may result in disappointment. Expectations that are too high will be a threat to the concept. As the PCMH concept gains momentum, it is important to recognize that a great deal of work still needs to be done for the theory to become a successful reality.

For updates on data regarding the patient-centered medical home, see the following articles:


REFERENCES


