Patient-Centered Medical Homes

In a recent survey, almost three out of four Americans reported difficulty accessing care from their doctor. Half report poor coordination of care; especially among those who see more than one doctor. One in three Americans reports getting unnecessary care or duplicate tests. Ninety one percent believe it is important to have one place or doctor responsible for their primary care and coordinating care.[i] Patient-centered medical homes are a new trend in delivering health care built around coordinating care and putting patients at the center of the system. Both bills currently being debated in Congress rely heavily on patient-centered medical homes for reforms.[ii]

Patient-centered medical homes are not buildings or hospitals, but a different way of practicing medicine. Patient-centered medical homes offer coordinated, comprehensive primary health care that is accessible, continuous, compassionate, culturally appropriate, and patient-centered. Coordination of care can reduce duplicate tests and prevent errors in conflicting treatment when patients have several doctors. Care is personalized for each patient and delivered by a team of professionals who put the patient and their needs at the center of care. The team may include a doctor, nurse, physician assistant, medical assistant, health educator and other professionals. Patient-centered medical homes can make primary care practice more appealing to graduating primary care physicians who are predicted to be in short supply as the US population ages.[iii] Proponents argue that patient-centered medical homes can reduce health care spending, improve health status, support disease management and prevention, improve the quality of care, reduce medical errors, and reduce racial and ethnic health disparities.[iv]

States are recognizing the potential of the patient-centered medical home model. Eight states have defined the patient-centered medical home concept in law or regulation and seven states are developing processes and criteria to recognize patient-centered medical homes.[v] Patient-centered medical home pilots and programs are operating across the country including New York, Connecticut, Maine, New Hampshire, Pennsylvania, Rhode Island, Vermont, and Massachusetts.[vi] In 2005 Ontario implemented the first wave of Family Health Teams, similar to patient-centered medical homes, to reduce emergency room use and expand access to preventive care.[vii] There are now 150 Family Health Teams across the province in areas of need, with 50 more in planning.[viii]

Preliminary research on the effectiveness of patient-centered medical homes is promising, but also offers caution and guidance for success including patience, flexibility and support.[ix] Researchers have found that implementing the patient-centered medical home model requires a fundamental transformation of medical practice, which can be difficult even for willing practices. It should be considered an on-going developmental process rather than a destination.[x]

Vermont's Community Health Care Teams integrate the patient-centered medical home model with health care financing, public health, prevention, clinical services and information technology. The project is unique in combining patient-centered medical homes focusing on individual care with larger public health services. Community Care Teams in three counties provide medical practices with direct services, care coordination, population management and quality improvement support.

Teams include a nurse care coordinator, social workers, behavioral health and substance abuse specialists, dieticians, community health workers, and public health prevention specialists. Teams are housed at local Department of Health District Offices. The teams collect data on community health needs including hospital discharges, behavioral risk factors, tobacco use, and highway safety data.[xi]

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