

**THE COUNCIL OF STATE GOVERNMENTS
RESOLUTION ON THE PATIENT-CENTERED MEDICAL HOME**

Resolution Summary

The Patient-Centered Medical Home (PCMH) is a health care delivery model designed to improve health, promote quality, and reduce the cost of health care that is centered primarily and explicitly on the needs of the patient. The PCMH is personalized care, access beyond the acute care episode, and integration of key medical and community resources to meet patient needs.

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for medical records of a child to be archived. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally sensitive care.

In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association—organizations dedicated to primary care representing more than 333,000 physician members—released the *Joint Principles of the Patient-Centered Medical Home*, with the following characteristics:

- **Relationship:** Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care
- **Team:** The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of the patients.
- **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. This includes care for all stages of life; acute, chronic, mental health, preventative, and end of life.
- **Integration:** Care is coordinated and integrated across all domains of the health care system and the patients' community. Care is facilitated by registries, information technology, and information exchange to assure that patients get the indicated care when and where they want it.
- **Quality and Safety:** Quality and Safety are hallmarks of the medical home. Through electronic medical records and technology providing decision-support physicians will be able to provide their patients with the most up-to-date evidence-based treatment options. This technology will facilitate physicians' ability to participate in measurement and quality improvement activities at the practice and system level.
- **Access:** Enhanced access to care is available through systems such open scheduling, expanded hours, and new options for communication between patients, physicians, and practice staff.

- **Value:** Payment is aligned to appropriately recognize the added value provided to patients who have a PCMH.

What does the PCMH look like?

Primary care is a complex set of tasks managed by a multidisciplinary team. This team works together to create high quality, personalized, integrated, comprehensive, accessible care that is safe and affordable.

The PCMH takes this care to a more personal level. For example, PCMH practices will ensure multiple access points for patients. Open scheduling will allow walk-ins and same-day appointments. Interactive Web sites will allow patients to access test results, correspond with their care team, request prescription refills, schedule appointments, and access their medical record. Technology will move patient self management to exciting new levels by giving patients resources for disease management and health education.

It is understood that measurement is essential for quality improvement. Through the technology afforded in EHRs, prospective data collection becomes a reality providing the physician and payers with real-time quality measures for the purpose of benchmarking, improvement and payment. The PCMH will offer online consultations and group visits which create efficiencies that should lower the cost of care for most patients while affording physicians more time to provide the quality care their patients and payers deserve.

The North Carolina's Medicaid program shows excellent quality and cost outcomes after adopting several components of the PCMH in their Community Care of North Carolina (CCNC) program. Through disease management payments, evidence-based clinical practice, and an emphasis on a team approach for case management they found significant improvements in cost, utilization, and quality measures. The program provides an additional per-member per-month case management fee, and an enhanced fee-for-service payment of 95 percent of the Medicare fee schedule for Medicaid covered services. Two major evaluations of this program estimated that the state saved \$195 to \$215 million in 2003 and between \$230 million and \$260 million in 2004 as compared to an alternative payment method (Wilson, C.F.). In recognition of this collaborative approach to meeting the health care needs of low-income children and families, the Ash Institute for Democratic Governance and Innovation at Harvard University's John F. Kennedy School of Government presented the Community Care of North Carolina Program with the "Innovations in American Government Award" on Sept. 25, 2007.

The PCMH aims to deliver the high level of practice outlined by the Institute of Medicine in *Crossing the Quality Chasm*. Primary care physicians recognize that they must transform their practices to provide better value for payers and even better care for patients. Evidence-based public policy will help facilitate the transformation of their practices into PCMHs.

The Commonwealth Fund 2006 Health Care Quality Survey finds that when adults have health insurance coverage and a medical home—defined as a health care setting that provides patients with timely, well-organized care, and enhanced access to providers—racial and ethnic disparities in access and quality are reduced or even eliminated. When adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially. The survey found that rates of cholesterol, breast cancer, and prostate screening are higher among adults who receive patient reminders, and that when minority patients have medical homes, they are just as likely as whites to receive these reminders. The results suggest that all providers should take steps to create medical homes for patients. Community health centers and other public clinics, in particular, should be supported in their efforts to build medical homes for all patients.

The United States health care system currently performs at a level considerably below its potential despite spending more on health care than any other nation. The United States does not have the best health care or the most effective health care system. Payers and patients alike are looking for better value in health care, desiring better quality of care for less cost. A recent study estimated that if every American had a medical home, health care costs would likely decrease by 5.6 percent, resulting in national savings of \$67 billion dollars per year with improvement in the quality of the health care provided (Spann, S.J.).

With the enactment in 2006 of the *Tax Relief and Health Care Act*, CMS will implement a three-year medical home model demonstration project in eight states. The project recognizes the medical home provides guidance to both the patient and other health care professionals based on an integrated, coherent plan for ongoing medical care developed specific to the patient. The medical home model should result in improved coordination of care, better care management, a decrease in duplicative tests and avoidance of hospitalizations for all patients, but especially for those patients with one or more chronic conditions, thus resulting in health system savings.

Resources

American Academy of Family Physicians

<http://www.futurefamilymed.org>

American Academy of Pediatrics:

http://aappolicy.aappublications.org/policy_statement/index.dtl#M

American College of Physicians

<http://www.acponline.org/advocacy/?hp>

American Osteopathic Association

<http://www.osteopathic.org>

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Patient-Centered Medical Home Program Management Directives

Management Directive #1: CSG staff will prepare correspondence to Governors and legislative leadership in the states, District of Columbia and territories notifying them of the approved resolution and encouraging them to implement and fund pilot programs to demonstrate the quality, safety, value, and effectiveness of the patient-centered medical home.

Management Directive #2: CSG staff will post approved resolution on CSG's Web site and make available through its regular communications venues CSG support of the Joint Principles of the Patient-Centered Medical Home as a guideline for states, the District of Columbia and territories to improve the health of its citizens.

THE COUNCIL OF STATE GOVERNMENTS
Resolution on the Patient-Centered Medical Home

WHEREAS, the patient-centered medical home provides a whole-person orientation that includes care for all stages of life, acute care, chronic care, preventive services, and end of life care; and

WHEREAS, patients in a patient-centered medical home actively participate in decision-making and feedback is sought to ensure patients' expectations are being met; and

WHEREAS, care in the patient-centered medical home is integrated across all elements of the health care system and the patients' community to assure that patients received the indicated care when and where they need in a culturally and linguistically appropriate manner; and

WHEREAS, when minorities have a medical home, racial and ethnic differences in terms of medical access disappear as noted in "Closing the Divide: How Medical Homes Promote Equity in Health Care" as published by the Commonwealth Fund (June 2007): and

WHEREAS, four national physician organizations (AAP, AAFP, ACP, AOA) representing more than 333,000 physicians across the country have developed joint principles that describe the characteristics of the patient-centered medical home; and

WHEREAS, The National Committee for Quality Assurance is developing a patient-centered medical home designation program for physician practices meeting specific criteria; and

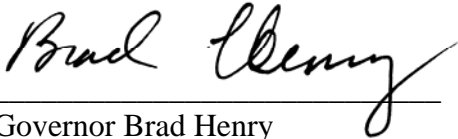
WHEREAS, a patient-centered medical home for every American has a potential national savings of \$67 billion per year with improvement in the quality of health care provided; and

WHEREAS, the federal *Tax Relief and Health Care Act* calls for a three-year medical home demonstration project to be conducted in eight states with an estimated start in 2009;


BE IT THEREFORE RESOLVED, that the Council of State Governments support the Joint Principles of the Patient-Centered Medical Home as a guideline for states to improve the health of its citizens, and

BE IT FURTHER RESOLVED, that the Council of State Governments encourage states to implement and fund pilot programs to demonstrate the quality, safety, value, and effectiveness of the patient-centered medical home.

Adopted this 14th Day of November, 2007 at the
CSG Annual State Trends and Leadership Forum
in Oklahoma City, Oklahoma



Governor Brad Henry
2007 CSG President



Representative Deborah Hudson
2007 CSG Chair