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Editor's message

The medical home issue

The term *patient-centered medical home* is commonplace but its meaning and significance are less well understood.

Wikipedia defines the medical home, also known as a patient-centered medical home (PCMH), as an "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.

With substantial legislative changes being considered, Family Medicine is at a crossroads. We need to decide whether to stand center stage and coordinate the health care team in a PCMH or serve more peripherally as consultants. The future health care team in a PCMH may look quite different from the traditional model that we are accustomed to. Family Medicine has an opportunity to increase its responsibility to overall health care, but this will surely go to others if we pass on this opportunity. A recent article in *New England Journal of Medicine* demonstrated specialty interest in the PCMH ("Specialist Physician Practices as Patient-Centered Medical Homes," electronically posted by NEJM April 21, 2010).

Patients want high-quality care and access to their physician. The payers are demanding higher care quality and increased focus on chronic care outcomes. Ultimately, the patient will benefit most from disease prevention, an old concept that still precedes the incentives in our current health care system. The National Committee of Quality Assurance (NCQA) certifies practices as PCMHs established with the input of American Osteopathic Association, American Academy of Family Physicians, the American College of Physicians, and the American Academy of Pediatrics.

Key physician-directed principles of the PCMH include:

1. *Personal physician*: Each patient has an ongoing relationship with a personal physician who is trained to provide first contact and continuous and comprehensive care.
2. *Physician-directed medical practice*: The personal physician leads a team of individuals at the practice level who collectively take responsibility for ongoing patient care.
3. *Whole-person orientation*: The personal physician is responsible for providing all of the patient's health care needs or for arranging care with other qualified professionals.
4. *Care is coordinated and integrated* across all elements of the complex health care system and the patient's community.
5. *Quality and safety* are hallmarks of the medical home.
6. *Enhanced access to care* is available through open scheduling, expanded hours, and other innovative options for communication between patients, their personal physicians, and practice staff.
7. *Payment* appropriately recognizes the added value provided to patients who have a PCMH.

Key components of PCMH include the ability to provide:

1. Patient-centered care
2. Work in interprofessional teams
3. Evidence-based practice
4. The application of continuous quality improvement
5. The use of informatics
6. Constant innovation

In this issue, we have a number of articles that relate to the PCMH. In our cover article, Norman Vinn, DO, FACOFP, introduces a model of an innovative care provider who may be a central player in the medical home: the Residentialist. In this thought-provoking article, he explains the shortfalls of the hand-offs from inpatient to outpatient care and how we need to develop specialists who focus on keeping people at home. Tasleyma Sattar, DO, in an original research project, looks at patient perspectives on the utility of the medical home. Patient knowledge and desire for PCMH are assessed. Steven Kamajian, DO, FACOFP, provides a practical example of how the principles of the PCMH are used to manage chronic health conditions. Richard Snow, DO, provides a policy article on how the PCMH can be integrated into Family Medicine. He reviews current programs in use and explains key components. Thomas Zimmerman, DO, FACOFP, presents a compelling argument on why the time is now to engage in electronic health management systems in terms of meeting insurer's expectations and improving the financial status of your practice.

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Everyone agrees that electronic health records are a central aspect of the PCMH.

Useful resources for the interested reader include:

1. NCQA certification for PCMH. Available at: http://www.ncqa.org/Portals/0/PCMH%20brochure-web.pdf
2. Joint principles of the patient-centered medical home. Washington, DC: American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, 2007.
3. Berenson RA. Is there room for specialists in the patient-centered medical home? Chest 137:10-11, 2010
4. AOA podcast on the PCMH. Available at: http://www.youtube.com/watch?v=XGIC3uBDf50

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