The medical home offers a patient-centered model of care known as patient-centered medical home (PCMH). The foundation of a medical home is organized and continuous inter-professional care of patients. There are a number of common elements of PCMH identified in the literature. There are also challenges to implementation of PCMH.

**Objectives**

- Introduce the concept of patient-centered medical home (PCMH)
- Describe foundational elements of PCMH
- Identify challenges to implementation of PCMH

**Background**

Experts claim up to 40% of healthcare is unnecessary (Fox, 2010). Medical costs accounted for 62% of bankruptcies filed in the USA in 2009 (Himmelstein, Thorne, Warren, & Woolhandler, 2009).

**History**

Medical homes originated in the early 1960s among pediatric caregivers (Malouin & Turner, 2009).

The National Committee for Quality Assurance (NCQA) had a major role in establishing basic tenets for the medical home in 2009 (Carrier, et al., 2009).

Thirty-six family practice sites were chosen to participate from eight states in the National Demonstration Project. Over half of these practices came from Michigan (Carrier, et al., 2009; Nutting, et al., 2009; Rittenhouse & Shortell, 2009).

In 2011 The Michigan Primary Care Transformation (MiPCT) was the largest PCMH in the nation.

**Abstract**

The medical home offers a patient-centered model of care known as patient-centered medical home (PCMH). The foundation of a medical home is organized and continuous inter-professional care of patients. There are a number of common elements of PCMH identified in the literature. There are also challenges to implementation of PCMH.

**Foundational Elements of PCMH**

Elements of PCMH include access to care, quality assurance, team-based care, electronic medical records, information technologies, and payment incentives for value based care (Korda & Eldridge, 2011b; Scholle, Saunders, Tirodkar, Torda & Pawlson, 2011).

There is a need for more primary care providers since most medical school graduates are not specializing in primary care (Harcus, 2011).

Nurse practitioners (NPs) delivering primary care have met resistance in organized medicine and face inconsistent scope of practice regulations among states. In 2012 only 18 states allowed NPs to function independently as primary care providers, while 32 states required various levels of physician involvement (Cassidy, 2012).

PCMH models of practice incorporate evidence-based processes of care, including population-based care management facilitated by patient registries, performance measurement and improvement, point-of-care decision support and information technology (Rosenthal, 2008).

**Challenges to Implementation**

Cost savings from implementing the medical home model will require clinicians and practices to develop new business models and new staffing structures; incorporate new tools and technologies; and engage in new ways of working with health plans, consumers, and patients while continuing the daily work of providing patient care. Interprofessional models based on collaborative and patient-centered care will impact acute, outpatient, and community based delivery systems.

Because a medical home involves linking a constellation of coordinated, patient-centered services to a diverse patient population, practices will encounter geographical, logistical, technical, philosophical, and economic challenges, especially small and/or rural practices (Arar et al., 2011). Alliances with professional practice organizations, hospital systems, government agencies, and professional colleges can supply part of these resources, additional reimbursement, and change facilitators.

New reimbursement structures will be necessary to control costs. Single payment will be shared (method to be determined) among a college of healthcare partners for each patient’s care.

Also, primary care providers and office staffs will need to be educated, coached, and given feedback on their ability to develop new processes and communicate better both internally and with patients, other specialists, hospitals, emergency rooms, and various community resources, through periodic reassessment (Miller & Cohen-Katz, 2010).

The initial monetary cost and stress of implementing an EMR is considerable and may not enhance profit, especially in the early years. Adopting and negotiating the EMR was the primary reason 53% of physicians left private practice for employment in 2000-2012 (DelVecchio, 2012). Defining the leadership and practice players for the PCMH will require reorientation of some players, continuing education, and negotiation and innovation, but may lead to higher morale and job satisfaction (Lewis, 2012).

**References**

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**Conclusion**

The Patient-Centered Primary Care Collaborative (2009) has released studies involving over a million patients from thousands of PCMH sites that show significant cost savings, increased patient satisfaction, and improved quality of patient care (Grumich & Grundy, 2010).