



## ***Patient Centered Medical Home Model of Care is Good for Patients and Good for Our Health Care System***

The concept of “patient centered medical homes” is an approach to care that revolves around the patient—not around insurance coverage or providers. The medical home concept focuses on improving care coordination, where a clinician or a practice is responsible for coordinating and integrating a patient’s care and ensuring that the patient has access to supportive services. Patients are partners in care management and decision-making. Care is provided to the whole person, not just to treat a specific condition or illness.

Medical homes work. They work for patients, for care providers, and for the health care system. Medical homes build on the benefits of primary care. According to the National Partnership for Women and Families, studies show that comprehensive primary care services, such as those delivered by a medical home, result in higher patient satisfaction with care and bring significant health and cost benefits, including better prevention and wellness, reduced health disparities, and fewer hospitalizations.

The Commonwealth Fund reports that medical homes also increase efficiencies. Patients served in medical homes were less likely to undergo duplicative tests and more likely to have medical histories available during care visits. The Fund also reports that effective primary care management for patients with chronic conditions results in fewer medical complications, leading to fewer hospitalizations. A study of the MeritCare System in North Dakota shows that management of chronic diseases such as diabetes and asthma brings cost savings.

According to the Patient-Centered Primary Care Collaborative, researchers from RAND and the University of California at Berkeley evaluated care provided according to PCMH principles. The researchers evaluated almost 4,000 patients with diabetes, congestive heart failure, asthma and depression, and found that:

- Patients with diabetes had significant reductions in cardiovascular risk;
- Congestive heart failure patients had 35% fewer hospital days; and
- Asthma and diabetes patients were more likely to receive appropriate therapy.

Also cited by the Patient-Centered Primary Care Collaborative is a Mercer study of the North Carolina Medicaid program’s enrollment of recipients in a network of physician-directed medical homes. The study showed “that an upfront \$10.2 million investment for North Carolina Community Care operations in SFY04 saved \$244 million in overall healthcare costs for the state.”

Our current system is often inefficient because it pays for more care and services, rather than better health outcomes. Patients with chronic conditions often receive fragmented care from different providers and settings, resulting in duplicate tests and conflicting prescriptions and treatments. There are few incentives for providers to spend the necessary time coordinating a patient’s care. The medical home model shifts focus and resources into primary care and incentivizes providers toward quality care and outcomes, not more care.

To gain the most from the medical home model, it is critical that consumers are a part of the program design at all levels. Consumers are a critical voice—alongside providers and systems—as models are developed to ensure that care meets the users’ needs to improve health.

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