



Hawai'i Primary Care Association

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Community Health Centers and the Patient-Centered Health Care Home

The “medical home” concept was originated by Hawai'i's Dr. Calvin Sia and the American Academy of Pediatrics several decades ago and the idea has gained support among other primary care specialists as well. Community Health Centers (CHCs) are happy to see the medical home model gain currency as it closely patterns the CHC model with its standards for access, quality, cost-effectiveness and patient satisfaction. **Because CHCs offer an array of services beyond the medical, we prefer the term “Patient-Centered Health Care Home,” but the concept is the same.**

Definition and characteristics

“A Medical Home is not a building, house or hospital but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective.” (American Academy of Pediatrics)

The Patient-Centered Primary Care Collaborative, which represents the leading primary care medical associations, lists the following hallmarks of the Patient-Centered Medical Home (PCMH):

- Patients have a **continuous relationship** with a personal physician in a physician-directed practice.
- The practice has a **whole-person** orientation.
- Care is integrated and **coordinated**.
- **Quality and safety** are of central importance. Ideally, electronic health records (EHR) and other technologies are employed to support clinical decision making, measure performance, provide patient education, and enhance communication between providers and patients.
- Enhanced **access** is available.
- **Payment** for services appropriately recognizes the added value of the PCMH and importance of activities not confined to the typical reimbursable patient visit.

We would add another crucial component to the PCMH: **fostering and maintaining referral and communication** channels with other community providers, including business agreements that allow electronic sharing of critical patient records.

Why A Patient-Centered Medical Home?

US health care delivery is ineffective and expensive because the so-called “system” is made up of uncoordinated parts and has an over-reliance on specialty care. Primary care physicians are inadequately compensated by insurers and so fewer and fewer graduates are choosing this area, but more primary care physicians are the key to system improvement and cost-effectiveness. Good primary care not only protects patients but gets better clinical results and saves money. Internationally, systems that invest significantly in primary care get the best life expectancy and birth outcomes, while systems like ours are significantly more expensive and result in middling outcomes.

Cost-Effectiveness:

Studies show that the PCMH model gets better clinical outcomes and saves money because the sustained relationship between provider and patient results in:

- Better identification of health problems (specialists tend to see the things they're looking for and order a lot of tests related to those conditions).
- Less duplication in diagnostic testing.
- More accurate and earlier diagnoses because provider and patient have an established relationship.
- Greater compliance with recommended treatment and more appointments kept.
- Less emergency room use.
- Fewer hospitalizations.
- More complete preventive services.
- Better health status monitoring.
- Fewer prescriptions and better coordination of care for patients who get multiple prescriptions.

In 2003 the North Carolina Medicaid program invested \$8.1 million in a patient-centered medical home pilot project, which saved \$60 million compared to the previous year's expenditures. In the next year, their investment increased to \$10.2 million and savings burgeoned to \$124 million.

Efficacy:

In countries with national health programs that emphasize prevention and primary care, life expectancy rates are the highest in the world. Countries that give preferential treatment to specialists, even within a national health insurance program, have mediocre life expectancy rates similar to the United States'. In urban areas where specialists are numerous and available, the life expectancy rate adjusted for income, age, and education levels, is less than that of rural residents who generally have limited access to specialists. **An emphasis on prevention, from both an economic and a medical point of view, is by far the most effective way to approach health care.**