

Patient-Centered Medical Home Statements of Support

The patient-centered medical home model is generating broad support among a wide and diverse range of important health care stakeholders. They share the goals of improved delivery of comprehensive primary care and focus on better outcomes for patients, more efficient payment to physicians and better value, accountability and transparency to purchasers and consumers.

The following Statements of Support articulate how the patient-centered medical home is assuming a pivotal role in helping reform the U.S. health care system.



PATIENT AND CONSUMER GROUPS

“It is such a relief for parents and families to have a medical home that works for them and their children. Having to navigate the medical system for prevention purposes is hard enough. It becomes even more dizzying when your child is sick. In the end, medical care providers who partner with families make their work more efficient and effective. Families know best.”

Sophie Arao-Nguyen, Ph.D., Executive Director, Family Voices Inc.ⁱ

“Access to care through a medical home improves continuity and quality of care for all children, especially children with special health care needs and their families. Children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. AMCHP believes that medical homes should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.”

Nan Streeter, President of the Association of Maternal and Child Health Programs (AMCHP)ⁱⁱ

“The goal of the patient-centered medical home is for patients to have an ongoing relationship with a personal provider who leads a team coordinating their care.”

Sarah Thomas, Director of Health Care for the Public Policy Institute, AARPⁱⁱⁱ

QUALITY ORGANIZATIONS

“The medical home is an integral component of a changed US health care delivery system. It will take a concerted and collaborative effort by payers and purchasers to get thousands of practices around the country to truly transform, but those involved know that this is our best chance at transforming primary care. Bridge to Excellence will help support this effort by continuing to provide a core set of programs that enable this collaboration to take place, and appropriately award those physicians who transform their practices to provide patient-centered care and deliver on the improved clinical outcomes we anticipate through this model.”

François de Brantes, Chief Executive Officer, Bridges to Excellence^{iv}

“The patient-centered medical home has the potential to change the interaction between patients and physicians from a series of episodic office visits to an ongoing two-way relationship. The medical home puts the emphasis on the patient-doctor relationship where it belongs – and helps doctors work to keep patients healthy instead of just healing them when they are sick. Patients can no longer be silent partners in their care – they are active participants in managing their health with a shared goal of staying as healthy as possible.”

Margaret E. O’Kane, President, National Committee for Quality Assurance (NCQA)^v

“A medical home can reduce or even eliminate racial and ethnic disparities in access and quality for insured persons,” a new Commonwealth Fund report finds. “When adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially.”

The Commonwealth Fund 2006 Health Care Quality Survey^{vi}

“The patient-centered medical home puts the explicit emphasis on an established relationship between the patient and primary care physician. That relationship is fundamental to the delivery of care that is safe, effective, patient-centered, efficient, equitable and timely – the definition of quality care. Patients need ready access to a medical home to reach their full health potential as engaged managers of their health. And when care is needed, it is essential that the primary care physician acts as the catalyst for improved coordination of care and the active involvement of patients and their families.”

Alan P. Spielman, President and CEO, URAC^{vii}

“Regular, coordinated care through a physician-led team, with support from population health improvement providers, holds great promise in the fight against chronic conditions. Together, the patient-centered medical home and population health can realize this vision with their shared recognition of the physician as the leader of the care team; emphasis on coordinated care delivery; and use of existing and new technologies to ensure safety, efficiency, high-quality care, and ongoing patient communication.”

Tracey Moorhead, President and CEO, DMAA: The Care Continuum Alliance^{viii}

“Healthy employees are a valuable asset, and employee health is an investment employers are willing to make. ERIC supports the patient-centered medical home as a foundational building block for needed improvements in our health care delivery system. The patient-centered model improves employee access to care and engages consumers in the management of their own health. It also supports greater transparency in quality and cost by promoting improved clinical information systems and better accountability.”

Edwina Rogers, Vice President, Health Policy, ERISA Industry Committee^{ix}

PHYSICIANS AND PROVIDERS

“The American Academy of Pediatrics pioneered the concept of a medical home that provides coordinated, quality care for children and youth encompassing preventive, acute and chronic services. A family-centered partnership is the cornerstone of any medical home. This partnership is developed through a trusting, collaborative relationship between the medical home team and families, respecting their diversity and recognizing that they are the constant in a child’s life.”

Dr. Renee Jenkins, President, American Academy of Pediatrics^x

“The patient-centered medical home offers the opportunity to improve health care quality for all Americans. Through the PPC-PCMH, the National Committee for Quality Assurance (NCQA) is helping physicians understand what functioning as a patient-centered medical home means on a day-to-day basis for their practices and establishing standards to recognize physicians who provide this type of care.”

John Tooker, Executive Vice President and Chief Executive Officer, American College of Physicians^{xi}

“The idea of a medical home is no surprise to a family physician because that’s what we are to our patients. Successful, efficient health care systems have at their base a good primary care network, where every patient has access to a primary care physician and every patient has a medical home.”

Linda Siy, M.D., President., Texas Academy of Family Physicians^{xii}

“McKesson supports the Patient-Centered Primary Care Collaborative because of the need for multi-stakeholder collaboration to forge the much needed patient-centered medical home model.”

David Nace, M.D., Vice President and Chief Medical Officer, McKesson Health Solutions^{xiii}

PURCHASERS

“We will never have an effective, high quality, safe health care system without patient-centered primary care, delivered by physicians and teams of health professionals who are paid appropriately. We need major reforms which will require a broad-based, national collaborative to make this happen.”

Helen Darling, President, National Business Group on Health^{xiv}

“We need to reinstitute primary care as the backbone of the health care delivery system.”

Andrew Webber, National Business Coalition on Health^{xv}

“Wal-Mart joined the Patient-Centered Primary Care Collaborative because, as a large pharmacy provider, the company ‘strongly believes the future has to involve accelerating the adoption of electronic prescriptions.’ As a member of the collaborative, the retail giant ‘recognizes that an important part of our effort has to be in promoting the patient-centered medical home.’”

John Agwunobi, M.D., M.B.A., M.P.H., President for Professional Services, Wal-Mart^{xvi}

“The medical home does not serve as a gatekeeper but rather as a gateway to the health care system. A medical home is a real and virtual relationship with a doctor centered on a patient’s needs.”

Paul Grundy, M.D., Director of Health Care Technology and Strategic Initiatives, IBM^{xvii}

“The patient-centered medical home has served as a catalyst and organizing philosophy to refine our state care delivery system. It has brought stakeholders from both the public and private sector together to organize around a philosophy of care delivery that brings value to our citizens. This model serves to create value in our health care system through improving the quality of care delivered to patients and maximizing the value of each health care dollar spent.”

Julie Schilz, R.N., B.S.N., IPIP and PCMH Manager^{xviii}

PAYERS

“The patient-centered medical home encourages strong, meaningful relationships among families, their physicians and care teams, and their health plans. The result is care that is accessible, continuous, and compassionate with care deliverers and patients working together. In this model, patients are better empowered and ultimately can make more informed healthcare decisions for themselves and their families. The patient-centered medical home is a core tenet in ‘The Pathway to Covering America,’ the Blue Cross and Blue Shield recommendations to Congress and the American people for a better healthcare system for the future.”

Scott P. Serota, President and Chief Executive Officer, Blue Cross and Blue Shield Association^{xix}

“The patient-centered medical home represents a pro-active approach to guiding patients as they take a more active role in managing their own health and medical conditions. Creating a health care team with the patient at the center involves many challenges ranging from enhanced information support at the time of service to improving communication and educational skills.”

Thomas Simmer, M.D., Senior Vice President and Chief Medical Officer, Blue Cross Blue Shield of Michigan^{xx}

“We believe the patient-centered medical home model is a promising approach that facilitates moving from a fragmented health care system to a more coordinated system, improving satisfaction for our customers and their primary care providers.”

Jeff Kang, M.D., Chief Medical Officer, CIGNA^{xxi}

PHARMACEUTICALS

“Pfizer supports the Patient-Centered Primary Care Collaborative’s efforts to advance a patient-centered medical home that is ultimately centered on the patient and on the patient-physician relationship. The patient-centered medical home has the potential for better health outcomes for patients through better access to coordinated, patient-centric care that focuses not only on prevention and wellness but disease management strategies that encourage access to and adherence with appropriate therapies.”

Joseph M. Feczko, MD, SVP, Chief Medical Officer, Pfizer Inc.^{xxii}

“We must have an infrastructure in this country to educate, engage, treat, and coordinate care for patients. Chronic conditions represent 75 percent of all healthcare costs – the patient-centered medical home represents a critical ‘missing link’ to effectively prevent disease, control chronic conditions, and lower total healthcare costs.”

Janie Kinney, Senior Vice President, Federal Government Relations & Public Policy- GlaxoSmithKline^{xxiii}

“Merck supports the concept of the patient-centered medical home as one way in which health care providers can improve health care quality and patient outcomes. As a company actively engaged in research and educational efforts to help change the course of chronic disease, Merck views the principles behind the patient-centered medical home as an important response to the increasing number of patients with chronic conditions – and the significant gaps in health care quality that may arise from a system that emphasizes episodic treatment for acute care. Merck believes that coordinated and consistent care can result in better outcomes, in light of the high prevalence of chronic disease. Disease management activities are often most successful when fully integrated into a physician practice and supported by continuous and collaborative provider/patient care. The patient-centered medical home is one of many ways a health care provider can improve quality, advance patient outcomes and enhance value.”

Robert A. McMahon, President, U.S. Commercial Operations, Merck & Co., Inc.^{xxiv}

POLICYMAKERS

“Many people in the United States do not have access to high quality, point-of-entry primary care. And, there is substantial evidence that ‘sufficient access to high quality primary care results in lower overall health care costs and lower use of higher cost services, such as specialist, emergency room, and inpatient care.’ As a result of these factors, private and public payers are interested increasingly in developing new models of service delivery that better support the provision of effective, patient-centered primary care, including the patient-centered medical home model. The patient-centered medical home model calls for establishing primary care teams that attend to the multi-faceted needs of patients, and provide whole person, patient-centered care. Substantial evidence indicates that access to a medical home – defined as timely, well-organized care with enhanced access to providers – can reduce or eliminate racial and ethnic disparities in health outcomes.”

The National Academy for State Health Policy^{xxv}

“At a time when both healthcare costs and chronic illnesses are on the rise, we need a better way to provide care that is accessible, comprehensive, coordinated, and cost effective. The Medical Homes Act of 2007 would make federal funding available for states to provide care to our nation’s most vulnerable – low income children and families. The medical home model can reduce costs and improve quality of healthcare services for every person in America.”

Senator Richard Durbin (D-IL)^{xxvi}

“In my home state, Community Care of North Carolina (CCNC) gives Medicaid patients a ‘medical home’ to coordinate their health care needs. This one-stop shop for medical care provides patients with the coordination to ensure they have complete care. The Medical Homes Act provides the start-up funds to grow and expand successful programs like CCNC nationwide. Senator Durbin and I agree that health care can improve when patients have a medical home.”

Senator Richard Burr (R-NC)^{xxvii}

“Medical home initiatives have the potential to add value to the Medicare program. Ideally, through better care coordination, medical homes could enhance communication among providers and thereby eliminate redundancy and improve quality. They may also improve patients’ understanding of their conditions and their treatment and thus reduce their use of high-cost settings like emergency rooms and inpatient care.”

Christina Boccuti, M.P.H., senior MedPAC analyst^{xxviii}

“We must move away from a system that is fragmented and pays for expensive procedures toward one where a family has a medical home, providers coordinate their efforts and take advantage of technology to do so cheaply, and where the focus is on affordable quality outcomes.”

Senator John McCain (R-AZ)^{xxix}

“I support the concept of a patient-centered medical home, and as part of my health care plan, I will help providers establish them... As president, I will encourage and provide appropriate payment for providers who implement the medical home model, including physician-directed, interdisciplinary teams, disease management and care coordination programs, quality assurance mechanisms, and health IT systems which collectively will help to improve care for those with chronic conditions.”

Senator Barack Obama (D-IL)^{xxx}

THINK TANKS

“Consumers, employers, doctors and policymakers have had enough. They want change that goes beyond tweaking a broken system. They want dramatic change. A change that replaces today’s fragmented, costly paper-based approach with a cohesive, modernized system that improves individual health, coordinates care and reins in costs... Patient-centered primary care or the patient-centered medical home is a model that can help fix these problems.”

Newt Gingrich, former Speaker of the House of Representatives, Founder, Center for Health Transformation^{xxxi}

“While they cannot alone solve our health care affordability challenges, medical homes can substantially reduce total near-term health care spending in addition to raising quality of care. Today, roughly 60 million uninsured and underinsured lower-income Americans need physician and health plan leaders to jointly pursue this higher aspiration for medical homes.”

Arnold Milstein, Medical Director, Pacific Business Group on Health, National Health Care Thought Leader, William M. Mercer^{xxxii}

“All people deserve high quality care. At the same time, we must also improve the overall efficiency of our health system. The patient-centered medical or health home is one promising innovation that could help us achieve these essential and interrelated goals. A health home is a clinician team that helps guide patients through the health system, while engaging them in managing their own treatment. It also improves the ability of clinicians to deliver high value care by rewarding them for focusing on care coordination, preventive services, and disease management. Patients, especially those with chronic conditions, will be healthier, and our health system will see less unnecessary spending on duplicative tests and treatments. A health home model that puts the patient first and incentivizes providers to focus on improving health, not just providing services, will make patients healthier and increase the value of our health care dollar.”

Len Nichols, Director, Health Policy Program, New America Foundation^{xxxiii}

ⁱ Provided to the PCPCC

ⁱⁱ Provided to the PCPCC

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^{iv} BridgesToExcellence.org, *Five Years On: Bridges Built, Bridges To Build 2003-2008*

^v NCQA.com, 1/8/2008

^{vi} CommonwealthFund.org, *The Commonwealth Fund 2006 Health Care Quality Survey*, 6/2007

^{vii} Provided to the PCPCC

^{viii} Provided to the PCPCC

^{ix} Provided to the PCPCC

^x Provided to the PCPCC

^{xi} NCQA.com 1/8/2008

^{xii} TAFP.org 1/8/2008

^{xiii} Provided to the PCPCC

^{xiv} Provided to the PCPCC

^{xv} Provided to the PCPCC

^{xvi} *State News Service*, 5/14/2008

^{xvii} *Financial Weekly*, 3/12/2008

^{xviii} Provided to the PCPCC

^{xix} Provided to the PCPCC

^{xx} PR Newswire 6/3/2008

^{xxi} *Lab Business Week* 6/8/2008

^{xxii} Provided to the PCPCC

^{xxiii} Provided to the PCPCC

^{xxiv} Provided to the PCPCC

^{xxv} NASHP.org, *State Health Policy Briefing*, 5/2008

^{xxvi} Durbin.senate.gov 11/16/2007

^{xxvii} Congressional Press Release 11/16/2007

^{xxviii} MedPAC.gov, 3/5/2008

^{xxix} JohnMcCain.com, 4/28/2008

^{xxx} AAFP.org, 2008

^{xxxi} *Would You Run Your Business This Way?* Newt Gingrich and James King, M.D., 2007

^{xxxii} HealthAffairs.org, 9/10/2008

^{xxxiii} Provided to the PCPCC