

American Academy of Family Physicians (AAFP)  
American Academy of Pediatrics (AAP)  
American College of Physicians (ACP)  
American Osteopathic Association (AOA)

Joint Principles of the Patient-Centered Medical Home  
February 2007

*Introduction*

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

*Principles*

*Personal physician* - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

*Physician directed medical practice* – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

*Whole person orientation* – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

*Care is coordinated and/or integrated* across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

*Quality and safety* are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care

- 46 planning process driven by a compassionate, robust partnership  
47 between physicians, patients, and the patient's family.  
48 ■ Evidence-based medicine and clinical decision-support tools guide  
49 decision making  
50 ■ Physicians in the practice accept accountability for continuous  
51 quality improvement through voluntary engagement in  
52 performance measurement and improvement.  
53 ■ Patients actively participate in decision-making and feedback is  
54 sought to ensure patients' expectations are being met  
55 ■ Information technology is utilized appropriately to support optimal  
56 patient care, performance measurement, patient education, and  
57 enhanced communication  
58 ■ Practices go through a voluntary recognition process by an  
59 appropriate non-governmental entity to demonstrate that they have  
60 the capabilities to provide patient centered services consistent with  
61 the medical home model.  
62 ■ Patients and families participate in quality improvement activities  
63 at the practice level.  
64

65 **Enhanced access** to care is available through systems such as open scheduling,  
66 expanded hours and new options for communication between patients, their  
67 personal physician, and practice staff.  
68

69 **Payment** appropriately recognizes the added value provided to patients who have  
70 a patient-centered medical home. The payment structure should be based on the  
71 following framework:  
72

- 73 ■ It should reflect the value of physician and non-physician staff  
74 patient-centered care management work that falls outside of the  
75 face-to-face visit.  
76 ■ It should pay for services associated with coordination of care both  
77 within a given practice and between consultants, ancillary  
78 providers, and community resources.  
79 ■ It should support adoption and use of health information  
80 technology for quality improvement;  
81 ■ It should support provision of enhanced communication access  
82 such as secure e-mail and telephone consultation;  
83 ■ It should recognize the value of physician work associated with  
84 remote monitoring of clinical data using technology.  
85 ■ It should allow for separate fee-for-service payments for face-to-  
86 face visits. (Payments for care management services that fall  
87 outside of the face-to-face visit, as described above, should not  
88 result in a reduction in the payments for face-to-face visits).  
89 ■ It should recognize case mix differences in the patient population  
90 being treated within the practice.

- 91                           ▪ It should allow physicians to share in savings from reduced
- 92                           hospitalizations associated with physician-guided care
- 93                           management in the office setting.
- 94                           ▪ It should allow for additional payments for achieving measurable
- 95                           and continuous quality improvements.
- 96

97   **Background of the Medical Home Concept**

98   The American Academy of Pediatrics (AAP) introduced the medical home concept in  
99   1967, initially referring to a central location for archiving a child’s medical record. In its  
100   2002 policy statement, the AAP expanded the medical home concept to include these  
101   operational characteristics: accessible, continuous, comprehensive, family-centered,  
102   coordinated, compassionate, and culturally sensitive care.

103  
104   The American Academy of Family Physicians (AAFP) and the American College of  
105   Physicians (ACP) have since developed their own models for improving patient care  
106   called the “medical home” (AAFP, 2004) or “advanced medical home” (ACP, 2006).

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108   **For More Information:**

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110   American Academy of Family Physicians  
111   <http://www.futurefamilymed.org>

112  
113   American Academy of Pediatrics:  
114   [http://aappolicy.aappublications.org/policy\\_statement/index.dtl#M](http://aappolicy.aappublications.org/policy_statement/index.dtl#M)

115  
116   American College of Physicians  
117   <http://www.acponline.org/advocacy/?hp>

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119   American Osteopathic Association  
120   <http://www.osteopathic.org>

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