



American College of  
Emergency Physicians®

ADVANCING EMERGENCY CARE 

# POLICY STATEMENT

Approved April 2015

## *The Patient-Centered Medical Home Model*

Revised and approved  
by the ACEP Board of  
Directors  
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Board of Directors  
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The patient-centered medical home (PCMH) model envisions a health care delivery system in which patients have an ongoing relationship with a personal physician who provides comprehensive care. This physician takes responsibility for coordinating care with other providers. This model is predicated on patients having enhanced access to their personal physician, including expanded hours and same-day scheduling. Central to this model are the practice of evidence-based medicine, quality improvement, performance measurement, the increased use of information technology, and a revised payment system to compensate providers who perform the duties of a patient's medical home.

“Joint Principles of the Patient-Centered Medical Home” was issued in March 2007 by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA). The PCMH model has gained support as one approach to health care reform, and proponents of the model contend that it will improve the health of patients, reduce costs to the health care system, and, among other benefits, reduce crowding in emergency departments.

ACEP agrees with the basic tenets of the PCMH model, and supports the concept, as long as patients are provided continued access to high quality emergency medical care.

ACEP believes a patient-centered medical home should:

**1. Provide high-quality, safe, and efficient medical care.**

The PCMH should practice evidence-based medicine with accountability for continuous quality improvement and performance measurement with the use of information technology to optimize patient care, communication, and education.

**2. Provide patient access to a personal physician, the leader of a team of individuals who collectively take responsibility for the ongoing care of their patients.**

ACEP believes it would improve health care if every person had access to a personal physician with whom they had an ongoing relationship and who

would assume responsibility for providing all of the patient's health care needs including appropriate arrangement of care with other qualified health care professionals. The personal physician would also help the patient navigate our complex health care system to their best advantage. Much benefit of the model would be lost if the patient cannot secure a timely appointment with their physician, must see a host of different providers in large group practices, or be evaluated in an urgent care center or walk-in clinic by providers who have little or no experience with the patient.

**3. Ensure patients have the freedom to select specialists of their choosing and access emergency medical care when they feel they need it.**

While there will undoubtedly be pressure for the medical home providers to limit choices and restrict access in order to save costs, patients must not be restricted from access to medically appropriate tests and specialist consultations. Of utmost importance is that all patients have access to emergency medical care according to the "prudent layperson" standard when they believe they have an emergency and they should not be penalized if subsequent evaluation determines there was no serious medical diagnosis.

**4. Include the safety net of emergency care.**

Resources used to fund the PCMH model should not undermine nor compromise the emergency medical care system. Regardless of the anticipated benefits from having a medical home, there will still be millions of Americans who experience sudden onset of life-threatening illness and injury for which they will need access to emergency medical care. There will be instances in which the personal physician cannot see their patient expeditiously requiring the PCMH to offer unscheduled access. The medical home must be integrated with sources of acute care so that patients presenting with conditions such as chest pain, abdominal pain, suspected stroke, or other acute illness or injury receive an expeditious and efficient evaluation. Often an emergency department (ED) will be the most time- and resource-efficient modality for patients' evaluation and treatment. Furthermore, in a world with electronic medical records, the ED is easily included in the PCMH. There is also a serious and ongoing need for increased surge capacity and emergency medical preparedness for natural and man-made disasters.

ACEP supports the tenets of the PCMH model that seeks to provide ongoing access to a personal physician as a way to improve health care and reduce costs to the health care system. Patients should be able to readily access their PCMH for on-going care and concerns that can be appropriately addressed in an office setting. However, emergency medical care is a crucial element of our health care system. All patients must be allowed access to emergency medical care according to the "prudent layperson" standard when they perceive they are experiencing symptoms of an emergency condition. The PCMH must include unrestricted access to emergency services whenever the personal physician is unavailable or otherwise unable to meet the patient's health care needs.