American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

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The Patient-Centered Medical Home Model

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The American College of Emergency Physicians (ACEP) supports the concept of the patient-centered medical home (PCMH) which advocates access to a personal physician, the primary care physician (PCP), for all patients, to optimize health and reduce costs with the understanding that they must have access to high quality emergency medical care. ACEP believes that emergency medicine is an integral part of the PCMH. Patients should have ready access to their PCP; however, unrestricted access to emergency medical services is necessary whenever the PCP is unable to meet their patient's needs, or the patient perceives a need for emergency care. All persons belonging to a PCMH must be allowed access to emergency medical care according to the prudent layperson standard.[1,2]

The PCMH is based on principles which were 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).[3,4] The Joint Commission has established a certification program for the PCMH which is based on the Agency for Healthcare Research and Quality's (AHRQ) definition of a medical home.[5,6] It envisions a health care delivery system in which patients have an ongoing relationship with a personal physician. The PCMH has gained support as an approach to health care reform, and its proponents contend that it will improve the health of patients, reduce costs, and can reduce emergency department (ED) utilization.[7,8]

ACEP believes a PCMH should:

1. **Provide patients timely access to a personal physician, the leader of a team of individuals who oversees the state of their health.**
   ACEP believes it would improve the health of our nation if every person had timely access to a PCP who provided the longitudinal care necessary for health maintenance and treatment of ambulatory care-sensitive conditions (ACSCs).

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

3. **Recognize the safety-net role of emergency medicine.**
Resources used to fund the PCMH should not compromise the emergency medical care system. Regardless of the anticipated benefits from having a PCMH, 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 care. There will be instances in which the PCP cannot see their patients expeditiously, requiring the PCMH to offer unscheduled access. The PCMH must be integrated with sources of acute care so that its patients who present with conditions such as chest pain, abdominal pain, suspected stroke, or other acute illness or injury receive an expeditious and efficient evaluation. Often an ED will be the most effective modality in these circumstances.

Furthermore, patients often seek treatment of ACSCs in the ED as an alternative to scheduled primary care.[9] Though these patients should have a PCP or seek treatment from their PCP, the reality is that many do not.[10,11] Many such patients prefer the ED because of its ubiquitous availability, willingness to see them regardless of ability to pay, and the trust they place in the ED.[12] Given that so many Americans depend on the ED as their place of first resort, the importance of emergency medicine to the health maintenance of our population must be acknowledged.

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