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The Patient Centered Medical Home (PCMH) is rapidly emerging as one prototype for redesigning health care delivery, restructuring reimbursement, and reestablishing the critical value of primary care. The actual term “medical home” was introduced by the American Academy of Pediatrics (AAP) in 1967, initially referring to a central location for archiving a child’s medical record. In 2002, the AAP expanded the medical home concept to include care characterized as accessible, continuous, comprehensive, patient-centered, coordinated, compassionate, and culturally effective. In 2004, the American Academy of Family Physicians (AAFP) embraced the model in its Future of Family Medicine project report, and in 2006, the American College of Physicians (ACP) similarly issued a report endorsing the primary care medical home. Soon thereafter in 2007, the AAP, the AAFP, the ACP, and the American Osteopathic Association (AOA) wrote a document entitled the Joint Principles of the Patient-Centered Medical Home.1 The Principles of the PCMH include the following:

**Personal clinician:** Each patient has an ongoing relationship with a personal primary clinician trained to provide continuous and comprehensive care. **Clinician leads a team:** A team of individuals, led by the primary clinician, provides care and collectively takes responsibility for the ongoing care of patients. **Whole-person orientation:** All needs of the patient are addressed including the provision of acute, chronic, preventive, and end-of-life care. Care is provided in a culturally and linguistically appropriate manner. **Care is coordinated and integrated:** Care is coordinated across all elements of the complex health care system and the patient’s community, and is facilitated by registries and information technology. **Quality and safety:** Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes. Evidence-based medicine and clinical decision-support tools guide decision-making. Clinicians accept accountability for