

PATIENT CENTERED MEDICAL HOME

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PCMH
A HEALTH CARE SETTING PROVIDING COMPREHENSIVE
PATIENT CARE

A PARTNERSHIP

- ◆ Where the roles of the patient, physician and staff are fully understood and practiced
- ◆ Where an ongoing patient/personal physician relationship is encouraged

PATIENT FOCUSED CARE

- ◆ Treats the whole person through all stages of life
- ◆ Puts the needs of the patient first
- ◆ Engages patients in their care
- ◆ Provides self management direction and counseling

COMPREHENSIVE TEAM **APPROACH TO PATIENT** **CARE**

- ◆ Promotes open communication among physicians, office staff and other professionals to assure quality patient care
- ◆ Reduces gaps in care and duplication of tests and procedures

CARE COORDINATION

- ◆ Coordinates referrals to specialists and other community agencies
- ◆ Provides post-hospital follow-up and support electronically or by telephone
- ◆ Assists patients in navigating the complex medical system

READY ACCESS TO CARE

- ◆ Establishes same day appointments and extended office hours
- ◆ Provides after hours access to a clinical decision maker – doctor or nurse

CLINICAL INFORMATION **SYSTEMS**

- ◆ Utilizes patient registries & e-prescribing
- ◆ To monitor adherence to treatment and access to labs and test results
- ◆ To provide reminders, decision support and treatment information to patients
- ◆ To encourage safe/efficient prescribing practices

PAYMENT/REIMBURSEMENT

- ◆ Recognizes the value of a Patient Centered Medical Home
- ◆ Allows for achieving measurable, continuous quality improvement

PUBLICLY AVAILABLE **INFORMATION**

- ◆ Provides transparent, accurate physician information to assist patients in choosing a practice that will meet their needs