

### Principles of Patient Centered Medical Home Education

**PCMH** is a model of care which seeks to improve the quality, effectiveness and efficiency of care they deliver while responding to each patient's unique needs and preferences.

The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system, and is a philosophy of health care delivery that encourages providers and care teams to meet patients where they are, from the simplest to the most complex conditions. It is a place where patients are treated with respect, dignity, and compassion, and enable strong and trusting relationships with providers and staff. Above all, the medical home is not a final destination, instead it is a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs.

1. **PATIENT CENTERED:** Each patient has ongoing relationship with a personal provider trained to provide first contact, continuous and comprehensive care.
2. **PROVIDER DIRECTED:** The personal provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients, using a planning process driven by a compassionate, robust partnership between provider's, patients, and the patient's family. Patients have access 24/7 electronically or telephone access to a personal provider who leads the care team within the medical practice.
3. **WHOLE PERSON ORIENTED:** Patients actively participate in decision-making and feedback is obtained to ensure patients' expectations are being met.
4. **INTEGRATED AND COORINATED CARE:** The personal provider is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals, 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., sub-specialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Collaboration for any outreach will be done for better quality of care. The goal of the provider and the team is to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
5. **FOCUS ON QUALITY AND SAFETY:** clinical decision-support tools guide is used for decision making. Practices use the quality improvement process to continually improve patient outcomes and help patients and families make informed decisions about their health.
6. **ACCESS:** Enhanced access to care is available through systems such as expanded hours and new options for communication between patients, their personal provider and practice staff.
7. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education and enhanced communication.
8. Provider's in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.