

# Why the Medical Home Works: A Framework

#### **Feature**

#### Definition

## Sample Strategies

### Potential Impacts

Patient-Centered

Supports patients and families to manage & organize their care and participate as fully informed partners in health system transformation at the practice, community, & policy levels

· Dedicated staff help patients navigate system and create care plans

• Focus on strong, trusting relationships with physicians & care team, open communication about decisions and health status

Compassionate and culturally sensitive care

Comprehensive

A team of care providers is wholly accountable for patient's physical and mental health care needs includes prevention and wellness, acute care, chronic care

- Care team focuses on 'whole person' and population health
- Primary care could **co-locate** with behavioral or oral health, vision, OB/GYN, and pharmacy
- Special attention is paid to chronic disease and complex patients

Coordinated

Ensures care is organized across all elements of broader health care system, including specialty care, hospitals, home health care, community services, & public health

- Care is documented and communicated effectively across providers and institutions, including patients, primary care, specialists, hospitals, home health, etc.
- Communication and connectedness is enhanced by health information technology

Accessible

Delivers consumer-friendly services with shorter wait-times, extended hours, 24/7 electronic or telephone access, and strong communication through health IT innovations

- More efficient appointment systems offer same-day or 24/7 access to care team
- Use of e-communications and telemedicine provide alternatives for face-to-face visits and allow for after hours care

Committed to quality and

Demonstrates commitment to quality improvement through use of health IT and other tools to ensure patients and families make informed decisions

- EHRs, clinical decision support, medication management improve treatment & diagnosis.
- Clinicians/staff monitor quality improvement goals and use data to track populations and their quality and cost outcomes

Patients are more likely to seek the right care, in the right place, and at the right time

Patients are less likely to seek care from the emergency room or hospital, and delay or leave conditions untreated

Providers are less likely to order duplicate tests, labs, or procedures

Better management of chronic diseases and other illness improves health outcomes

Focus on wellness and prevention reduces incidence / severity of chronic disease and illness

Cost savings result from:

- Appropriate use of medicine
- Fewer avoidable ER visits, hospitalizations, & readmissions

safety

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