Patient Center Medical Home FACT SHEET

What is a patient centered medical home?
A patient centered medical home is a care team, led by a primary care physician that focuses on each patient's health goals and needs, and coordinates that patient's care across all settings.

The concept of a medical home was initially introduced by the American Academy of Pediatrics in 1967. In March 2007, the AAP, the American College of Physicians , the American Academy of Family Physicians, and the American Osteopathic Association issued the Joint Principles of the Patient Centered Medical Home in response to several large national employers seeking to create a more effective and efficient model of health care delivery.

Patient-Centered Medical Home is not an actual building, house or hospital. It's a team approach to providing comprehensive health care in a high-quality and cost-effective manner.

A **Patient-Centered Medical Home** is based on a continuous relationship with a personal physician. The physician leads a team of medical professionals who together take responsibility for a person's care through all stages of life. The patient has **one place to call;** they have **greater access** to services; they get **personalized care;** that care is **safe** and **scientifically valid;** and there is a focus on **preventive care** which keeps costs down and patients healthier.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

If you have any questions about Patient Centered Medical Home please ask the staff for a brochure or visit our web site.