

Patient-Centered Medical Home

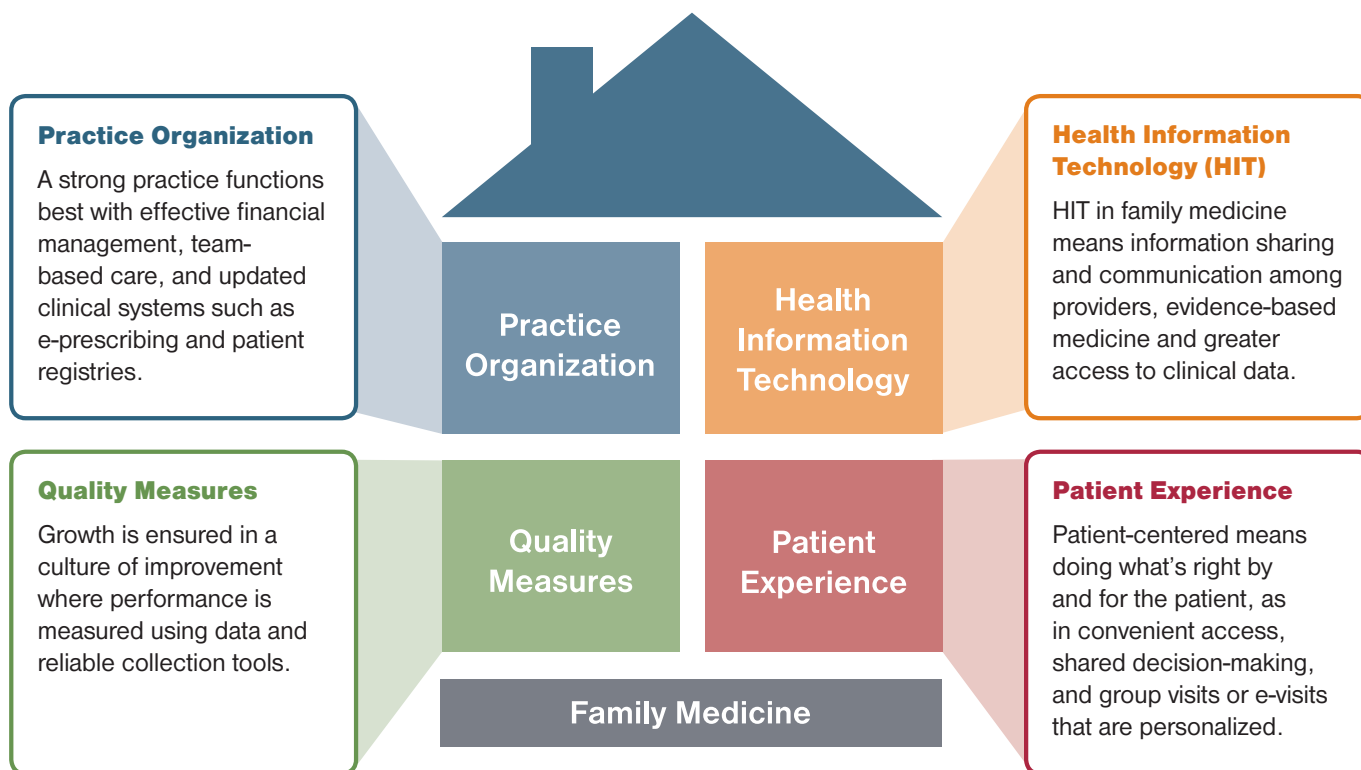
Current state of the U.S. health care system

- Ranked 37th in quality by the World Health Organization
- Spends more per capita than any other nation in the world
- 20% to 30% of patient tests and procedures are unnecessary and not beneficial

PCMH: The Future of Primary Care

The Patient Centered Medical Home (PCMH) is the future of primary care in the United States. Through a personal family physician, comprehensive care is coordinated and individualized to deliver better health outcomes such as:

- ↓ mortality and morbidity
- ↓ medication use
- ↓ per capita expenditures
- ↑ patient satisfaction
- ↑ greater equity in health care



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Questions for Medical Students to Ask Family Medicine Residency Programs

The following questions were designed to assist medical students who are interviewing with prospective residency programs to better understand the features of the PCMH and how individual programs have implemented the principles outlined.

Access to Care:

1. How does your program provide patient-centered enhanced access (e.g. evening or weekend hours, open-access (same day) scheduling, e-visits)?
2. How is the team concept practiced? What is the balance of open access to assurance of continuity with assigned provider? How does the PCMH concept carry over to the nursing home, hospital and other providers including mental health?

Electronic Health Records

1. What aspects of your medical home are electronic (e.g. medical records, order entry, eprescriptions)?
2. Does your practice use a Personal Health Record that allows patients to communicate their medical history from home to the healthcare team?

Population Management

1. Do you use patient registries to track your patients with chronic diseases and monitor for preventive services that are due?
2. Does your practice use reminder systems to let patients know when they are due for periodic testing (e.g. screening colonoscopy, PAP smear, mammogram) or office visits (e.g. annual exam)?

Team-Based Care

1. Who comprises your medical home team and how do they work together to deliver comprehensive care to your patients?
2. What services can non-physician members of the team (nurse practitioners, medical assistants, social workers, etc.) provide for patients (e.g. diabetic education, asthma education)? How do you train them and ensure competency?
3. How are you preparing residents to be a leader of a team?

Continuous Quality Improvement

1. How do you monitor and work to improve quality of care provided in your medical home?
2. How do you monitor your ability to meet patient's expectations (e.g. patient satisfaction surveys)?
3. How are residents involved in helping to enhance practice quality and improve systems innovations? Is CQI activity an integral part of the organized learning experience, and is it integrated with training in EBM activities?

Care Coordination

1. How does your practice ensure care coordination with specialists and other providers?
2. How does your practice ensure seamless transitions between the hospital and outpatient environment?

Innovative Services

1. What procedural services are offered in your medical home (e.g. obstetrical ultrasound, treadmill stress testing, x-rays)?
2. How does your medical home provide group visits (e.g. prenatal group visit)? For what types of problems are group visits used and who participates?

