**Patient Centered Medical Home (PCMH) is coming to OFD !**

Back in November of 2011, I wrote a blog on our website discussing the importance of adopting an Electronic Health Record (EHR) into our medical practice. A couple of months later I followed that up with a blog on Meaningful Use and how this government incentivized program would help improve the quality of care provided at Our Family Doctor. Well, it is now time to introduce to our patients the third aspect of the ‘quality improvement trifecta’ known affectionately as *PCMH*, or the Patient Centered Medical Home.

Some of you may have heard of this new care model, though I suspect most of you have not. Rest assured though, you will certainly hear a lot about the *PCMH* care model in the coming years as the landscape of healthcare delivery continues to evolve in our country. Over the coming months, OFD patients will begin to see many changes cropping up at the practice, so I wanted to give you a little ‘heads up’ on the direction that we will be heading. Let’s start with an overview of the five primary clinical essentials of the *PCMH* care model.

***TEAM BASED CARE***: Within the *PCMH,* each member of the care team has their own unique role to play and works together with other team members to deliver patient centered preventive services, chronic disease management and complex care coordination. The team forms a working culture where the physician, medical assistant and other staff members collaborate so that all members of the team are functioning at the top of their licensure and skill sets.

***PATIENT REGISTRY***: The *PCMH* will maintain various lists of patients with particular conditions so that evidence-based parameters can be used to guide care and insure that the patients are receiving all that is necessary to reach their care management goals.

***EVIDENCE-BASED CARE AND PROTOCOLS:*** The *PCMH* will use care management guidelines and protocols for preventive services and chronic disease care that are based on clear medical evidence and are available to all members of the clinical team.

***PATIENT ENGAGEMENT IN SELF-MANAGEMENT OF CHRONIC DISEASE CARE:*** The *PCMH* will develop a collaborative approach between patients and the care team using a shared agenda and clearly defined responsibilities that enhances the patient’s skills, education and self-efficacy in order to best manage their chronic disease.

***COMPLEX CARE AND DISEASE MANAGEMENT OF “HIGH RISK” PATIENTS:*** The *PCMH* will identify “high risk” patients such as those requiring frequent office visits, recently hospitalized patients, readmitted patients, those taking many medications and those with special needs. With the use of a Nurse Navigator to handle complex case management, care coordination and transitions between levels of care, and/or the use of a Clinical Pharmacist to assist patients with either high-risk medications or multiple medications, the *PCMH* will endeavor to deliver more comprehensive medical care.

At Our Family Doctor, we are committed toward improving ourselves as a practice and improving the care that you receive as our patients. We have chosen to fully embrace the *PCMH* care model as the vehicle by which we will achieve our goals. Over the next year, we will be testing various changes and workflows, will be seeking input from our patients, will be implementing new protocols that follow the five goals previously outlined, and hope that you will enthusiastically join us on our journey as we evolve into the 21st century medical practice that we endeavor to become.

Stay tuned for more *PCMH* updates in the coming months.

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