



Principles for Patient- and Family-Centered Care: The Medical Home from the Consumer Perspective

As organizations representing a broad and diverse array of consumer interests, we believe that the following set of principles should guide the development and implementation of the medical home model of care.

- 1. In a patient-centered medical home, an interdisciplinary team guides care in a continuous, accessible, comprehensive and coordinated manner.**
 - The patient is the center of the care team. Family members and other caregivers may also be a central part of the team.
 - The care team includes professionals inside the medical office or health center, as well as clinical and non-clinical professionals in the community.
 - The team provides initial and routine assessments of the patient's health status, and places a high priority on preventive care, care coordination and chronic care management to help patients get and stay healthy and maintain maximum function.
 - The care team is led by a qualified provider of the patient's choice, and different types of health professionals can serve as team leader.

- 2. The patient-centered medical home takes responsibility for coordinating its patients' health care across care settings and services over time, in consultation and collaboration with the patient and family. The care team:**
 - Helps patients choose specialists and obtain medical tests when necessary. The team informs specialists of any necessary accommodations for the patient's needs.
 - Helps the patient access other needed providers or health services (including providers or health services not readily available in the patient's community, e.g., in a medically underserved area).
 - Tracks referrals and test results, shares such information with patients, and ensures that patients receive appropriate follow up care and help in understanding results and treatment recommendations.
 - Ensures smooth transitions by assisting patients and families as the patient moves from one care setting to another, such as from hospital to home.
 - Has systems in place that help prevent errors when multiple clinicians, hospitals, or other providers are caring for the same patient, such as medication reconciliation and shared medical records.
 - Has systems in place to help patients with health insurance eligibility, coverage, and appeals or to refer patients to sources that can be of assistance.

- 3. The patient has ready access to care. The care team:**
 - Ensures that patients can schedule appointments promptly – on the same day if needed – and experience brief office waiting times.
 - Guarantees that a member of the medical home clinical team is available by phone, e-mail or in person nights, weekends, and on holidays. A responsible team member has ready access to the patient's information and is always able to communicate with the patient, using interpreter services and translated materials if needed.
 - Accommodates the needs of patients with limited physical mobility, English proficiency, cultural differences or other issues that could impede access to needed examination and treatment and patient self-management.
 - Facilitates patients' ready and appropriate access to services from other providers, such as mental health or reproductive health care providers. The medical home is not a "gatekeeper," but rather facilitates connections to other providers and services, as appropriate.

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4. The patient-centered medical home “knows” its patients and provides care that is whole person oriented and consistent with patients’ unique needs and preferences. The care team:

- Has ready access to the patient’s complete, up-to-date medical history. The team also ensures that patients and authorized family caregivers have access to this information.
- Takes into consideration the patient’s life situation, including family and caregiver circumstances, his or her values and preferences, age, and home environment when making recommendations about the patient’s health care and treatment plan.
- Communicates with patients in culturally and linguistically appropriate ways.

5. Patients and clinicians are partners in making treatment decisions. The care team:

- Helps patients and others designated by the patient understand their condition and the results of any medical tests or consultations with specialists.
- Provides unbiased, evidence-based information on all treatment options, including possible side effects, costs, and the benefits and risks of different options (including alternative therapies), so that patients can make an informed choice that reflects their personal preferences.
- Does not withhold information about treatment options from patients based on assumptions about ability to pay.
- Provides patients with timely access to results of laboratory and other diagnostic tests through such means as telephone, email, fax, personal health records, or patient portals.
- Makes use of e-reminders, especially for preventive care services.

6. Open communication between patients and the care team is encouraged and supported. The care team:

- Communicates with patients in a way they understand and prefer. They encourage questions and two-way conversation that helps patients and their caregivers (when appropriate) effectively manage their health and be full partners in their health care.
- Knows about and overcomes any language, cultural, literacy, or other barriers to effective communication with patients, family members and other caregivers.

7. Patients and their caregivers are supported in managing the patient’s health. The care team:

- Integrates culturally appropriate community-based support resources such as social services, transportation, peer support groups, and exercise programs.
- Works with patients to develop their capacity to stay well and manage their health conditions.
- Assesses and accommodates patients who are unable to effectively manage their own care because of cognitive or physical challenges, by working with family caregivers, legal surrogates or other sources of support.
- Works with the patient or their caregiver to develop, plan and set goals for their care and helps the patient meet those goals.
- Ensures that no treatment decisions are made without the patient’s consent and understanding.

8. The patient-centered medical home fosters an environment of trust and respect. The care team:

- Treats patients, family, and/or other caregivers with dignity and respect.
- Guarantees that patients can trust that their personal health information is never shared or used without their knowledge.
- Ensures that examinations and discussions with or about patients take place in a setting that affords appropriate privacy from other patients or staff.

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9. The patient-centered medical home provides care that is safe, timely, effective, efficient, equitable, patient-centered and family-focused. To accomplish this, the care team:

- Seeks out and encourages patient feedback on their experience of care, and uses that information to improve the quality of care they provide.
- Collaborates with patient and family advisors in quality improvement and practice redesign.
- Collects data on race, ethnicity, gender, primary language, and language services for each patient and records that information in a manner that can be reported and used to plan and respond to the health and language needs of patients in the practice.
- Regularly evaluates and improves the quality, safety and efficiency of its care using scientifically sound measures and reports that information to an entity that will make it publicly available in a way consumers can understand and access.
- Routinely undertakes efforts to identify and eliminate any disparities in the quality of care received by its patients.

These principles are provided in the context of patient-centered medical home initiatives, which should include changing the way providers are paid so they are both incentivized and adequately compensated for providing the high quality, patient-centered care envisioned in these principles.

Organizations subscribing to this statement of principles:

AARP
AFL-CIO
Alzheimer's Association
American Diabetes Association
American Hospice Foundation
Asian & Pacific Islander American Health Forum
(APIAHF)
Bazelon Center for Mental Health Law
Center for Medical Home Improvement
Center for the Advancement of Health
Childbirth Connection
Community Catalyst
Community Health Alliance of Humboldt –
Del Norte (CA)
Consumers Union
Consumer Worker Coalition (MN)
Families USA
Family Voices

Institute for Family-Centered Care
Leadership Conference on Civil Rights
Medicare Rights Center
NAACP
National Alliance for Caregiving
National Consumers League
National Council of La Raza (NCLR)
National Family Caregivers Association
National Health Law Program (NHeLP)
National Partnership for Women & Families
National Women's Law Center
Peer Outreach and Education Team
(Humboldt County, CA)
SEIU
Universal Health Care Action Network of Ohio
Western New York Association of Diabetes
Educators (NY)

For more information, please contact the National Partnership for Women & Families at 202-986-2600, or visit www.nationalpartnership.org/medicalhome