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PC-MH Mission, Vision, Goal, Access, End-of-Life

RI.01.04.02 The Organization provides patients with information about the functions and services of the primary care medical home.

The Mission, vision and goals of the primary care medical home

Mission

The mission of the primary care medical home is to transform healthcare in order to achieve The Triple Aim: improved care, improved outcomes and decreasing the cost of that improved care. The mission is sensitive to the fact that quality and safety of healthcare is decreased by delay in care, incompleteness of care, inconsistency of care and incomprehension of the content of care.

Vision

The vision of the primary care medical home is the transformation of the care received in the medical home to be:

1. A collaborative effort between all members of the healthcare team including the patient, the ambulatory staff, and the healthcare providers (nurse practitioners, physician assistance, physicians).
2. No longer is care to be delivered and/or received in a paternalistic, didactic setting. It is not to be the result of a shared-decision making, an activation and engagement of the patient in his/her care.
3. No longer is car to be received at the convenience of office hours in the ambulatory clinic but the care will be delivered and received at the time and place of greatest need. The collaboration will take place at all hours and at all locations.
4. Continuity of care will not be driven by geography, i.e., delivered only at a provider's office, or be personality based, i.e. only be available when a unique person is available, but continuity will be maintained as the patient's health record:

    a. is available at all times,
    b. in all places and
    c. additions and/or deletions to that record will be done at all sites in the same record at all times..
    d. The mission vision is expanded from a primary care medical home to a medical neighborhood which spans the boundaries of type of medicine which is practice

and where all information from all providers participating in a patient's care is simultaneously available if not through the same EHR, then through the Heath Information Exchange and/or the interoperability of different EHRs.

Goal

The goal of primary care medical home is to improve the process of the care being delivered which will provide both improved experience of care and improved healthcare, to improve the outcomes of healthcare which will provide improved health to the individual and to the community, and to decease the cost of that care while maintaining and improving its quality, which will make the process and outcomes sustainable

Conclusion -- SETMA's primary care medical home achieves the above by:

1. Using the same EHR at all sites of care: clinic, emergency department, inpatient, nursing homes, provider's homes, etc.
2. Having medical home team members available 24 hours a day by telephone, secure web portal and/or encrypted testing and in person at clinic, hospital and emergency department.
3. Having expanded hours for scheduled appointments.
4. Multiple "electronic huddles" each day and night where medical home team members communicate with one another by secure e-mail, iphone and by secure, encrypted texting to discuss patient's care and recommended treatment.
5. Clinical Systems Support which standardize care regardless of which member of the team is delivering care and when all members of the team are not physically available.
6. Both respecting and expecting the patient's participate in their care, respecting and committing to carrying out their end-of-life wishes, employing expanded members of the medical home team when available such as home health, physical therapy, hospice, etc.

Scope of Service

SETMA's primary care medical home provides a list of services on our website and also discusses those services in person with the patient. Even in the case of services provided by SETMA, we respect the patient's right to receive care in other settings even when those services are available in SETMA. For instance, when a patient needs to see an eye specialist, even though one of SETMA's partners is a board-certified ophthalmologist with fellowship training in diabetes eye disease, if the patient has a long-standing relationship with an eye specialist and wishes to maintain that relationship, SETMA supports that decision.

Materials Given to Patients at their First Appointment Includes the following:

- An acknowledgeable that the patient ahs the right to select and also to change their principle contact as far as a healthcare provider within the medical home.
- At each visit, shared-decision making is part of the patient-centric conversation. SETMA's providers discuss this and continue to learn about it at our monthly training sessions for all providers from all clinics. All of SETMA's disease management tools include "plans of care and treatment plans" and all care decision are discussed with the patient.

- SETMA has an extensive referral tracking program which is described on our website. In addition, no referral is completed unless it has been discussed with the patient and the patient has agreed with the need for and their willingness to follow through on the referral.
- All SETMA's care is coordinated by the provider in collaboration with SETMA's Care Coordination Department. That is described on our website and to our patients.
- When specialty care or consultation is required, the patient participates in the decision to make the referral and in the person to whom the referral is made. In today's healthcare culture often the patient's greatest concern is "is that doctor in my network." SETMA respects the right of the patent to get care from a provider covered by his/her insurance. When the patient's preference is based on past experience, we respect that as well.

Accessing the Primary Care Medical Home

SETMA has published information about how to contact the medical home:

1. During office hours
2. After office hours
3. In emergencies
4. For questions that are not emergencies

Patient Responsibilities and Rights

SETMA has published statements of patient responsibilities and rights as they participate in the primary care medical home. The patient's rights include the right to consultations and to second opinions.

Respecting Patent's End-of-Life Decisions

As part of a primary care medical home, SETMA initiatives the decision about end-of-life decisions, code status and the making of a living will or advanced directives. SETMA works with the patient to make rational decisions when further care is futile but respects the patient's rights in they choose decisions with which we do not agree. If, in an inpatient setting, the patient's family or medical power of attorney wishes to pursue futile, SETMA goes through a compassionate, patient-centric decisions making process consistent with medical ethics and the hospital by-laws. At this time the primary care medical home team is expanded to include clergy, case managers and others. SETMA has an advanced directive template which we offer to patients during the discuss about end-of-life issues. If a patient or family is not comfortable talking about end-of-life issues, we respect that and recommend speaking to their clergyman.