Principles of Patient-Centered Medical Home

1. Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

2. Physician directed – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients, using a planning process driven by compassionate, robust partnership between physicians, patients, and the patient's family.

3. Whole-person orientation – patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

4. The goal of the physician and the team is to assure that patients get the indicated care when and where they are need and want it in a culturally and linguistically appropriate manner.

5. Care is coordinated and integrated – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals, for all stages of life: acute care, chronic care, preventative services, and end of life care. 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).

6. Quality and safety – evidence based medicine and clinical decision –support tools guide decision making.

7. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

8. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication

9. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.