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PATIENT-CENTERED MEDICAL HOME & TEAM-BASED CARE: TWO COMPLEMENTARY MODELS TO ACHIEVE OPTIMUM BENEFITS FOR PRACTICES & PATIENT CARE DELIVERY

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The Patient-Centered Medical Home (PCMH) model of care and the Team-Based Care Model share several important characteristics:

- Goal to provide comprehensive, timely, proactive care and care coordination for patients
- Focus on the patient at the center of care delivery, i.e., a patient-centered approach
- Utilize the full team; everyone working at the top of his/her license and qualifications
- Conduct a daily huddle to increase communication and collaboration within and across practice teams

The PCMH model of care and the Team-Based Care Model both support physician practice transformation and work to strengthen and improve overall care delivery, which is critical to success in a value-based reimbursement environment. **The two models are complementary and can be combined to achieve optimum benefits for the practice and for patient care delivery.**

The **PCMH Model** emphasizes a population-health based approach to care delivery, including identifying and proactively addressing the care needs of specific patient populations in accordance with evidence-based clinical guidelines; identifying patients who may benefit from care management and utilizing a risk-stratification process to identify and prioritize high risk patients; implementing processes to track and coordinate care and care transitions; and measuring and monitoring overall quality and safety of care.

In particular, the **Team-Based Care Model** involves a restructuring of clinical workflows to promote increased sharing of responsibilities across the entire team, enhancing practice efficiency while improving patient, provider, and staff engagement. Key elements and core principles of the Team-Based Care Model include:

- **Co-location** of the care team in a common flow station (i.e., workstation) to increase communication and collaboration in real time
- **"Co-visit"** with MA/nurse documenting the visit in real time in patient's EMR while provider examines and interacts with the patient. Increases accuracy and timeliness of documentation and reduces providers' after hours "pajama time" to complete charting.
- **Pre-visit Planning** such as review of EMRs for upcoming patient visits to identify gaps in care, needed prescription refills, and chronic disease follow-up; enter pre-visit orders into EMR per standing orders and protocols

For more information about the PCMH and Team-Based models of care and how Stroudwater can help you transform your practice, please contact Louise Bryde, MHA, BSN, RN at 404-790-8251 or lbryde@stroudwater.com.