

Health Care Home, also known as “Medical Home” offers a team approach to primary care with a common goal of making it easier for patients to communicate and partner with a primary provider. The goal of our Medical Home is to promote high quality care by using a care team approach. Care teams can include: clinicians, nurses, specialists, pharmacists, care coordinators, community resources and any other resources needed for a full perspective of medical care.

At UFM, all Medical Home participants work directly with a care coordinator who develops a relationship with patients and their families and works with them to coordinate care with a goal of achieving better health outcomes for the patient. This includes streamlining access to appointments, improving communication with specialists, answering questions over the phone, assisting with referrals and pre visit planning and providing assistance with their healthcare needs.

For the patient, Medical Home offers a sense of guidance and direction with the clinic and the healthcare system in general which can sometimes feel overwhelming and difficult to navigate. Being part of a team approach, we help the patient direct his or her care by using nationally recognized standards of care in conjunction with a patient’s culture, preferences, and input. An individual care plan is developed to help the patient manage their care wherever that care is needed.

United Family Medicine is currently certified with the State of Minnesota as a certified Patient Centered Medical Home. This allows the clinic to receive monthly per person care coordination payment for patients with multiple chronic conditions, patient who have been diagnosed with Diabetes and patients who frequently over utilize emergency rooms for primary care.

Medical Home helps ensure that patients get the right care, at the right time, at the right place.

To be certified as a Medical Home, United Family Medicine meets a rigorous set of standards that are required for re-certification. Samples of the standards include the following:

- ✓ Access and communication: a system to support effective communication among team members, the patient and the medical providers
- ✓ A patient registry: a searchable electronic patient registry to record participant information and track patient care
- ✓ Care Coordination: a system of care coordination that promotes patient and family centered care
- ✓ Care plan: an individualized guide for patients with complex or chronic conditions

- ✓ Performance Improvement: implementation of a quality improvement process that focuses on the patient's experience, health and cost-effectiveness of care.

The development of a Medical Home in primary care clinics is an important part of Minnesota's health reform law that aims to improve the health of the population, the patient experience and the affordability of health care.

For more information or if you would like to talk with someone about joining our Medical Home please contact one of our Medical Home Coordinators. IF you are unsure what team you are on, please call the main number at 651-241-1000

#### Medical Home Coordinators

Blue Team	Tom Herman, LPN	651-241-1109
Red Team	Dolores Ledezma, LPN	651-241-1178
Yellow Team	Connie Youso, LPN	651-241-1061
Hospital Care Coordinator	Susan Herzog, RN	651-241-1158