

BENEFITS OF PCMH

Adopts the principles of patient-centeredness
Better Outcomes
Documented value of primary care
Fewer hospital admissions
Fully exploit health information systems
Improved patient compliance/outcomes
Lower utilization of Urgent Care or Emergency Department
Reduce mortality

28th MDG Mission

Multi-Capable Medics generating total force readiness and high reliability health care

28th MDG VISION

Comprehensive, integrated healthcare cultivating ready forces for global strike and nuclear deterrence

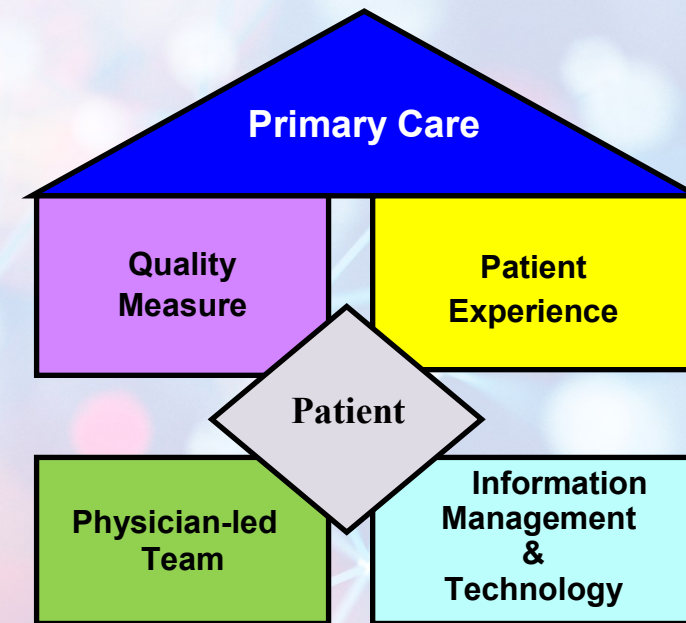
GOALS/OBJECTIVES

Create MDG Culture, Identity, and Buy-In
Improve our Readiness Posture
Self-Sufficient Resilient Airman
Accessible, holistic military healthcare through innovative solutions

CLINICS & SERVICES AVAILABLE

24/7 Ambulance Service (EMT)
Allergy
Behavior Health Optimization Program (Provider & Nurse)
Bioenvironmental Engineering
Case Management
Dental (AD Only)
Diagnostic Imaging
Disease Management
Exceptional Family Member Program
Family Advocacy Program
Family Health (Tatanka)
Flight Medicine
Health Promotions
Immunizations
Laboratory
Mental Health (AD Only)
Minor Outpatient Procedures
New Parent Support Program
Nurse Advice Line (24 hour)
Optometry (AD Only)
Pediatrics
Physical Therapy (AD Only)
Public Health
Warrior Operational Medicine (Raiders)
Women's Health

PRIMARY CARE MEDICAL HOME



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WHAT IS THE PRIMARY CARE MEDICAL HOME?

- The PCMH is a primary care model that delivers the core principles of primary health care.
- Patient-centered, comprehensive care, coordinated care, superb access to care, system-based approach to quality and safety.
- PCMH is used to improve health care by transforming how primary care is organized and delivered.
- PCMH is incorporating secure messaging that allows patients to communicate electronically with their health team and receive non-urgent health advice at their convenience.
- This partnership focuses on sustaining and enhancing readiness and health in enrolled patients and optimal, efficient delivery of comprehensive health care services based on the needs of enrolled patients.
- The PCMH model is based on a solid primary care platform, including continuous access to a personal provider. This team is responsible for all of the patient's health care needs, a practice built on patient-centeredness, principles, and fully leveraged use of health information and communication systems.

WHO'S ON YOUR TEAM

You (the patient)
Primary Care Manager
Technicians
Nurses
Pharmacists
Ancillary Services
Disease Manager
Case Manager
Mental Health Specialists
Physical Therapists

PATIENT RESPONSIBILITIES

Actively participate in your care decisions

**Ask clarifying questions to ensure you make
informed decisions**

If you're a Disease Management patient, set

**self-management goals in conjunction with your provider
team**

**Provide accurate, up-to-date, complete health information,
including current medications, complaints, past illnesses,
hospitalizations, work history, and other health matters**

**Know your primary care provider and team (if you're not
sure who they are, please ask for clarification and infor-
mation)**

**If needed, ask for translation services; please don't hesi-
tate to ask. We want to ensure you have a clear under-
standing of your medical care**

**You have the right to request a second opinion within
your primary care medical home. Please let staff know if
you would like a second opinion.**

CORE PRINCIPLES

Personal Provider: Each patient has an ongoing relationship with a provider trained to provide continuous and comprehensive care (**provider/directory information is available for review in the TRICARE Operations Center** to allow you to choose your provider (staff can direct you to the directory) located in the TRICARE Operations Office.

Team-Based: Provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. You (the patient) are involved in your treatment plan.

Whole person orientation: Respects patient values, cultural traditions, language, and socioeconomic conditions.

Coordinated, Comprehensive, and Integrated Care: Provider is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with qualified professionals. For coordination of specialty care or second opinions, please contact your primary care provider about any health concerns or information. We provide educational information for all stages of life, acute care, chronic care, preventive services, and end-of-life care across all elements of the complex health care system. It is important you participate in your care. Follow medical advice, set goals as recommended, and provide accurate information to your provider.

Quality and Safety: Committed to quality and safety at all times

Enhanced Access and payment reform: Achieving outstanding outcomes for patients. (Nurse advice line available 24 hours/day.)