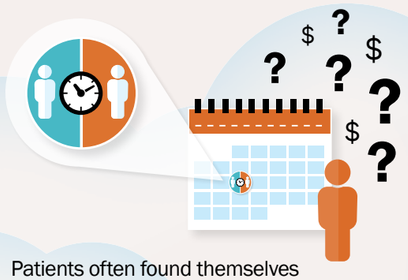
Putting You at the Center of Personalized Primary Care

In the past, primary health care was centered around a yearly doctor's appointment that could leave you feeling a bit on your own in the time in-between.



Patients often found themselves wondering about important aspects of their health, and providers were not set up to succeed in their efforts to coordinate personalized care for their patients.

A major reason for this gap was the lack of communication and coordination among providers and across sites of service. That's why Cheshire Medical Center/Dartmouth-Hitchcock Keene (CMC/DHK), like many medical centers throughout the country, has adopted a better way to care for our patients.

Today, our patients benefit from a health care model that brings together a coordinated team led by a Primary Care Provider.

Your Medical Home Team

Whether it's helping you get the most from your appointments, following up on tests and recommendations, prescribing and monitoring medications, facilitating transitions of care, consulting on behavioral health issues, coordinating support services, or tracking records and paperwork, your team has got you covered.

Health care coordinated to meet YOUR specific needs.

Other members of your team include:

- RN Care Coordinator
- Results Management Nurse
- Medication Renewal Manager
- Team Phone Nurses
- Behavioral Health Consultant
- Forms Manager
- Patient Flow Staff
- Call Center Receptionists

To learn more about the members of your Medical Home Team, visit: **cheshire-med.org/familymedicine**

Understanding a Patient-Centered Medical Home (PCMH) Model

It's not a place...it's an enhanced partnership with your Primary Care Provider.

Taking a Collaborative Approach.

Primary Care Providers (PCP) collaborate with Associate Providers and other members of your team to address your specific health concerns. They also work with you to create health and wellness goals and a plan to reach those goals.

Associate Providers partner with your PCP to ensure your current treatment plans are being followed. They diagnose, as well as prescribe treatment and medications.

Collaborative Care Nurses (CCN) work closely with you and your PCP to help manage chronic conditions. With ongoing check-ins, you and your CCN focus on education, mentoring, and health coaching. CCNs also oversee lab tests, and health screenings, and monitor the progress of preventative care protocols.

Registry Coordinators make sure that patients are getting their routine and preventative screenings and are up-to-date with their PCP's recommendations for chronic illness management.

Let's look at an example of how a PCMH flexes to address an individual patient's needs. Below are just some of the team members who might work with you through a diagnosis of type 2 diabetes.

Primary Care Provider meets with you to examine and discuss your health. Determines that lab work is required and orders testing. Develops and oversees your treatment plan and directs your care.

Results Management Nurse contacts you with test results and your PCP recommendations. Communicates directly with your PCP to help answer your questions about test results and arranges appropriate follow-up care.

Collaborative Care Nurse works closely with you and your PCP to provide education, coaching, and ongoing support to help you stabilize and manage your diabetes.

Registry Coordinator reachs out to you between office visits to ensure you are up-to-date with chronic and preventative guidelines, such as the A1C test to review your average blood glucose level over the past few months.

Diabetes Care Network

In addition to your PCMH, you have the resources of the Diabetes Care Network at CMC/DHK, a team of specially trained and certified clinicians working with you in concert with your Medical Home Team to provide a multifaceted approach that includes medical care, coping skills, and assistance with lifestyle change.

Key components of the PCMH:

Accessibility, Communication, and Connection

Seamless connections among our walk-in care clinic, specialty services, and family medicine help your team always stay on the same page when it comes to your care.

You never need an appointment to be seen by one of our Dartmouth-Hitchcock medical staff at CMC/DHK Walk-In Care. Open 365 days a year, our walk-in care clinic can treat your everyday illnesses and minor injuries.

To learn more about CMC/DHK Walk-In Care, visit: **cheshiremedwalkin.org**

Save time and stay in touch with myD-H Keene, an electronic patient portal that allows you to use your computer, tablet or smartphone to:

- access your records
- send and receive secure messages with your provider
- request, reschedule, or cancel appointments
- request prescription renewals

To learn more about myD-H Keene, visit: **cheshiremed.org**

Teaming up in the Community

CMC/DHK is committed to working with our community partners to address population health and wellness issues and collaborate on supportive solutions.

Our Medical Home Teams help patients connect with regional resources and educational opportunities.

The Cheshire Diabetes Prevention Program is an example of this partnership in action. CMC/DHK, together with the Keene Family YMCA, Monadnock Family Services, and the Keene Senior Center, have partnered to offer this year-long program that can help to cut the risk of type 2 diabetes by half.

To learn more, visit **cheshiremed.org/diabetes**. To talk with someone about signing up for the next session, call **(603) 354-6866.**

Cheshire Medical Center
Dartmouth-Hitchcock Keene
cheshiremed.org