The Key Elements:
Using the Patient Centered
Medical Home Model in Inter-Professional Education and Training

Medical, Dental, and Public Health Education

Curriculum Transformation

Primary Care Residency Training

Quality Patient-Centered Medical Care

College-wide Patient-Centered Medical Home Program Meharry Medical College

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Purpose of this Webinar

To integrate:

1. principles and practice of the PCMH model through developing training curriculum for all students including the elements of
   - access and continuity of care;
   - team-based care and care coordination;
   - care management using evidence-based practice;
   - patient self-care support and community resources;
   - population health management; and
   - continuous quality improvement.

What is Patient Centered Medical Care

- Enhances Access and Continuity of Care
- Identifies and Manages Patient chronic illnesses
- Plans and Manages Care through team-based services
- Provides Self-Care Support and Community Resources
- Tracks and Coordinates all Care within a special space.
- Uses Performance Measurement and Quality Improvement to insure population health

Foundation of PCMH

- The foundational elements of the model are:
  1. Personal physician, physician directed medical practice, whole person
  2. orientation, care is coordinated and/or integrated,
  3. quality and safety, enhanced access, and
  4. payment reform. Specific features of the PCMH model

Specific Elements of the PCMH

1. **Each patient has an ongoing relationship with a physician that provides continuous, comprehensive care;**
2. **Care is provided by physician-led teams;**
3. **Care teams arrange care for all stages of life (acute care, chronic care, preventive care and end of life care);**
4. **Care is coordinated across all elements of the health care system;**

Specific Elements cont'd

1. **Care is facilitated by disease registries and information technology;**

2. **Enhanced access is available through expanded hours and advanced-access scheduling and improved communication options between patients, their personal physician, and practice staff;**

3. **Quality and safety are ensured through the use of continuous quality improvement, evidence-based medicine and clinical decision-support tools, and;**

4. **the payment system is reformed to recognize the added valuate provided to patients.[4,5]**

PCMH Key Elements

- Strengthening the link between recognition and practice performance on quality, cost, and
- patient experience metrics;
- Increasing practice engagement while reducing non-value added work;
- Leveraging practices' investment in health information technology to help support PCMH recognition; and
- Aligning PCMH recognition activities with other reporting requirements.

Creating Patient-Centered Team-Based Primary Care Curriculum

- Introduced by American Academy of Pediatrics (AAP) in 1967, and initially referred to a central location for medical records.
- National Academy of Medicine (Formerly known as Institute of Medicine) defines patient centered as: the provision of health services to individuals, families and/or their communities by at least two health care providers who work collaborative with patients and their caregivers.
- Agency for Healthcare Research and Quality (AHRQ) is a stakeholder in Patient centered medical care.
- The National Committee for Quality Assurance (NCQA) works to improve health care quality through the PCMH model emphasizing concepts of team-based care and patient centered care.
- Team based care is how the PCMH is applied in the clinical setting.

The Relationship: Primary Care & Patient-Centered Practice

- NCQA PCMH has been targeting Primary Care
- Primary Care has been the focus of innovative reimbursement models
- The federal government funding for innovative in primary care the last 8 years has been significant
- Primary Care is the gateway to maintaining good health and reduce ER visits
- Primary Care allows providers and patient to focus on preventive care and chronic disease management

Key places to learn more

- Department of Family and Community Medicine
- The MacColl Center for Health Care Innovation
- The Cambridge Health Alliance
- AHRQ's Team Steps to Primary Care
- The Safety Net Medical Home Initiative
- Health Affairs Patient Center Medial Home (2009-13): Providers, Patients and Payment
- NCQA PCMH 2015 Scoring for Level I, 2, 3

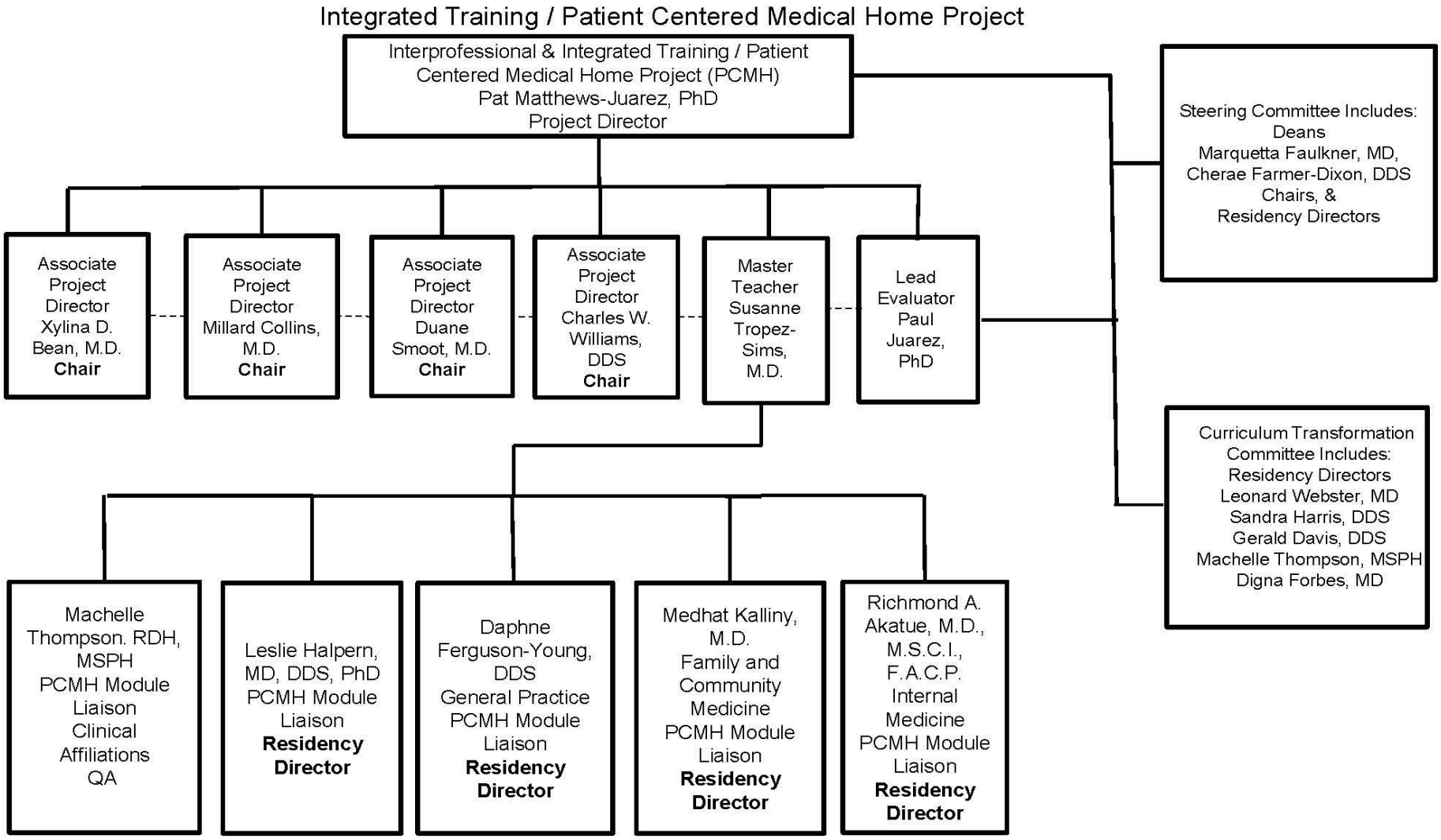
Summary points Webinar #1

1) Train and expose students and residents to the PCMH practice;
2) PCMH model requires the integration of the use of how providers will be required to use EMRs as a standard practice;
3) The importance of the team-based care, electronic health record, and quality assurance in population health; and
4) Improving the overall health of communities.

Typical Block for Practice Management and Community Health

Practice Management Grid				
Monday	Tuesday	Wednesday	Thursday	Friday
Work with Project Manager on one Guideline update	Work with case manager on a QA project of a chronic disease or health maintenance	Work with Chair of the evidence-based review	Staff front desk/Billing and Coding Training	Web portal staffing
Weekly Meeting with TennCare Staff/ train, review practice indicators	Continuity Clinic	Continuity Clinic	Continuity Clinic	Practice Management Project
Community Medicine Grid				
Monday	Tuesday	Wednesday	Thursday	Friday
Work with Project Director on one Guideline update	Work with case manager on a QA of a chronic disease or health maintenance	Work with Chair on 1 evidence-based review	Community Assessment and Principles of Community Based care	Project Work
Continuity Clinic	Continuity Clinic	Community health center	Community health center	Continuity Clinic

Attachment 3 Organizational Chart



Thank you

- Questions?