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

Webinar 2

Medical, Dental, and Public Health Education

Curriculum Transformation

Primary Care Residency Training

Quality Patient-Centered Medical Care

College-wide Patient-Centered Medical Home Program
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# What is a Patient Centered Medical Home: Refresher

- 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

# Goal of Webinar 2

- To provide an overview of three standards of PCMH and Explore alignment and curriculum transformation opportunities.

1. Enhances Access and Continuity of Care
2. Identifies and Manages Patient chronic illnesses
3. Plans and Manages Care through team-based services

# Standard 1 Key Elements

- PCMH : 1. Enhances Access and Continuity of Care
- Definition: The practice provides access to culturally and linguistically appropriate routine care and urgent team-based care that meets the needs of patients and family.
- **Examples include:** access to after office hours, electronic access to the provider team, continuity of care in practice, same day appointments, culturally & linguistically appropriate services and patient can select his/her provider.
- **Curriculum Opportunities:** Design practice opportunities for medical students, residents, and community physicians in training to actively lead team development of polices and procedures which support enhance and support access and continuity of care.

# Standard 2 Key Elements

- PCMH: 2. Identifies and Manages Patient chronic illnesses
- Definition: The practice systematically records patient information and uses it for evidence based chronic disease management.
- Examples include: basic patient information, use of an EHR, searchable data fields, clinical data and diagnosis, list of prescription drugs, measures BMI, health assessment, population health benchmarks, and integration of the EHR to track high risk chronically ill patients.
- Curriculum Opportunities: Introduce students to the use of EHRs and the alignment of care plans associated with all patients with a focus on chronic disease management.

# Standard 3 Key Elements

- PCMH: 3. Plans and Manages Care through team-based services
- Definition: The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse care.
- Examples include: team planning for care, engagement of community resources, written care plans, partnership with patient and care givers,
- Curriculum Opportunities: Design educational sessions, including grand rounds, small group discussions, and curriculum modules which focus on team-base care, care planning with multi-disciplinary members, which include the patient, family and caregivers. Include meaningful use standards.

# Standard 4 Key Elements

- PCMH: 4. Patient self-care support and community resources
- Definition: The practice acts to improve patients' ability to manage their health by providing a self-care plan, tools, educational resources and ongoing support.
- Example include: assessing patient and family care management skills, works to develop a care plan, provide tools and resources for self management, mental health, dental and substance abuse alignment, and counsel on healthy behaviors.
- Curriculum Opportunities: Design practice management and physician shadowing experiences, which allow students and residents to work across primary care, dentistry and public health in care planning thru partnership with individuals, families and care givers.

# Standard 5 Key Elements

- PCMH: 5. Population Health Management
- Definition: practice has a electric system to track patients test, referrals, facilities, providers and align all transitions in care.
- Examples include: track lap test, flagging high risk patients through continuous quality improvement, electronic medical record, electronic communication between patients and relevant referrals, integrate the meaningful use elements, and complete system of tracking care across all transitions.
- Curriculum Opportunities: Curriculum must address how students and residents pursue the alignment with EHR adoption, public health, and outreach to community organizations for specialty care.

# Standard 6 Key Elements

- PCMH: 6. Continuous Quality Improvement
- Definition: The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.
- Examples include: use of performance and patient experience data to address real time improvements, practice identifies and tracks vulnerable populations, practice can measure improvement in care, and measures which track health care cost.
- Curriculum Opportunities: The introduction of the basic PDSA cycle of improvement developed by IHI. In addition, the use of Six Sigma as another consistent approach to CQI.

# Summary Points

- Curriculum should include discussions on the practical use of EHRs
- Curriculum should include information on meaningful use
- Curriculum should provide interactive opportunities for engaging patients and families
- Curriculum should include education on culturally, linguistically appropriate care
- Curriculum should provide team based patient meetings
- Curriculum should include care planning opportunities
- Curriculum should include the use of CQI tools and methods

# Thank you

- Questions?