**Week 1- The Medical Home and CIM clinic**

**WHAT IS THE MEDICAL HOME**

* + - A concept not a physical place
      * + started in the 1970’s in pediatrics🡪CF clinics, other pediatric chronic illnesses 1990’s
        + Ed Wagner, Chronic Care Model, now Medical home
        + Called the PACT team-patient aligned care team at the VA
    - There are specific criteria for being a “medical home”

**DISCUSS ASPECTS OF THE MEDICAL HOME**

* Coordinated care—team based care
  + - Multidisc teams
    - Coordinated way to get outside records etc.

**How do you measure this?** Team assignments, huddles, working to the top of your license

* Access
  + - Appts, after hours, wait times, alternative ways of access, 3rd next available, team based care

**How do you measure this?** See above, telephone, alternative types of appointment-nursing etc

* Patient Centered
  + - Pt satisfaction, means thoughtful approach to providing care for pts, eg language/education specific information, social issues/barriers
    - Bringing care to patient
    - Self management

**How do you measure this?** Press Ganey—problems with this, decision support tools, documentation of goals

* Comprehensive Care—
  + - access to MH services, Social work, pharmacy, other subspecialty care in clinic

**How do you measure this?** Who else is in clinic, VA behavioral medicine, clinical pharmacist, social work

* Quality and safety—systems approach
  + - Report on population measures for patients and performance on measures
    - Understand quality improvement for systems(Thursday AM curriculum)

**How do you measure this?** Clinic goals with performance measures, population data—diabetes registry, opioid registry, patient compass

Practice some of these tools in CIM clinic, multidisciplinary team, patient centered care, telephone clinics