**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