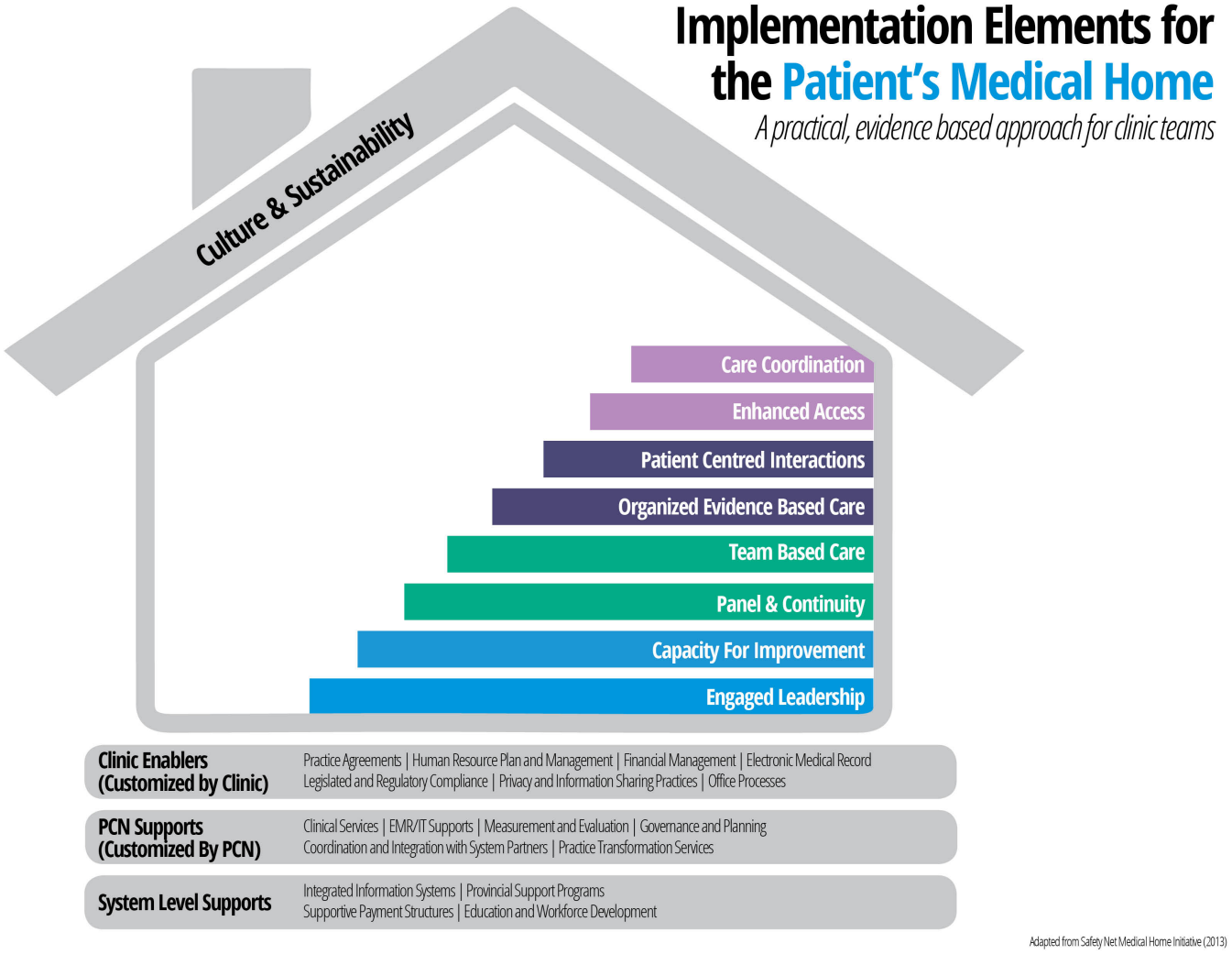
Patient's Medical Home
Implementation Elements and High Impact Changes Overview



Implementation Elements and High Impact Changes[1]

- The eight implementation elements are described from a 5 year demonstration project whose goal was to develop a replicable, sustainable model for implementing the Patient's Medical Home.
- Each of the implementation elements below include descriptor statements as general advice about the types of changes required in transitioning to a Patient's Medical Home model.
- The Patient's Medical Home Assessment can also be used to help understand key features of a PMH practice.
- Each practice must decide how to implement these elements in their organizational structure and context, however change packages have been developed to support practice teams with a set of high impact changes, potentially better practices, and tools to guide practice teams.

[1] The implementation elements and element descriptors have been adapted from the Safety Net Medical Home Initiative

ELEMENT 1: ENGAGED LEADERSHIP FOR THE PRACTICE

- Provide visible and sustained leadership to enable a cultural change as well as support specific strategies that will improve quality and spread change
- Ensure that the medical home transformation effort has the time and resources needed to be successful
- Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model
- Build the practice's values on creating a medical home for patients into staff hiring and training processes

ELEMENT 2: QUALITY IMPROVEMENT (QI)

- Establish and monitor metrics to assess improvement efforts and outcomes; ensure all staff members understand the metrics for success
- Optimize use of health information technology to provide proactive patient care
- Ensure that patients, families, providers, and care team members are involved in quality improvement (QI) activities
- Choose and use quality improvement models and tools, such as PDSA cycles, process mapping, etc…

ELEMENT 3: PANEL & CONTINUITY

- Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis
- Assess practice supply and demand and balance patient load accordingly
- Use panel data and registries to proactively contact, educate and track patients by disease status, risk status, self-management status and community and family need

ELEMENT 4: TEAM BASED CARE

- Establish and provide organizational support for care delivery teams accountable for the patient population/panel
- Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care
- Ensure that patients are able to see their provider or care team whenever possible
- Define roles and distribute tasks among team members to reflect the skills, abilities, and credentials of each person

ELEMENT 5: ORGANIZED EVIDENCE BASED CARE

- Use planned care according to patient need
- Identify high risk patients and ensure they are receiving appropriate care case management services
- Use point-of-care reminders based on clinical guidelines
- Enable planned interactions with patients by making up-to-date information available to providers and the care team at the time of the visit

ELEMENT 6: PATIENT CENTERED INTERACTIONS

- Respect patient and family values and expressed needs
- Encourage patients to expand their role in decision-making, health-related behaviors, and self-management
- Communicate with their patients in a culturally appropriate manner, in a language and at a level that the patient understands
- Provide self-management support at every visit through goal setting and action planning
- Obtain feedback from patients/family about their healthcare experience and use this information for quality improvement

ELEMENT 7: ENHANCED ACCESS

- Promote and expand access by ensuring that established patients have 24/7 continuous access to their care team via phone, email or in-person visits
- Provide scheduling options that are patient- and family-centered and accessible to all patients

ELEMENT 8: CARE COORDINATION

- Link patients with community resources to facilitate referrals and respond to social service needs
- Integrate behavioral health and specialty care into care delivery through co-location or referral protocols
- Track and support patients when they obtain services outside the practice
- Follow-up with patients within a few days of an emergency room visit or hospital discharge
- Communicate test results and care plans to patients/families