Workforce Competencies for Patient-Centered Healthcare Delivery through Health IT: A Framework for Practice Transformation

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Curricula Resources: Patient-centered Medical Home (PCMH)

PCMH Detailed Competency	PCMH Learning Objectives	Resources/Recommendations
Definitions and Principles		
Describe the history and background of PCMH	Describe the broad historical significance of PCMH	http://www.dhcs.ca.gov/provgovpart/Documents/PCMH_Vision_to_Reality.pdf • Explores the concept of the PCMH, its relationship to the planned care model, the growing support for the concept from purchasers, consumers, physicians and insurers • Explains plans for demonstration and pilot projects in the private and public sectors
	Recognize key milestones in the introduction of PCMH, from concept to policy	http://www.pcpcc.net/content/history-0 • Lists key milestones in the introduction and development of PCMH, starting from 1967 to present
Define major PCMH concepts	Describe the core features and joint principles of PCMH	http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home • Lists the joint principles and core features of PCMH http://www.graham-center.org/online/graham/home/publications/monographs-books/2007/rgcmo-medical-home.html • The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change; organizes some of the evidence that is foundational to the PCMH concept and identifies key elements of a medical home for delivering a patient-centered experience
	Distinguish the standards for meeting specific PCMH elements	http://www.coachmedicalhome.org/coaching-curricula/introduction • Curriculum Outline: Provides tools and resources to support practices striving for medical home transformation and NCQA PCMH™ Recognition
Explain the goals of PCMH	Define Triple Aim and how it relates to PCMH	http://wwww.pcpcc.net/guide/evidence-quality • Web site: Defines the goals of the Triple Aim: improve the experience of care, improve the health of populations, and reduce per capita costs of health care
	Explain patient-centered health care	http://www.emmisolutions.com/medicalhome/transformed/ • Video: Introduction to the Patient Centered Medical Home

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	Explain patient-centered health care	http://www.youtube.com/watch?v=g3eNW_CmG1o • Video: Family Physicians Support Patient Centered Medical Home Model of Care
	Identify the importance of sustainability	http://archive.pcpcc.net/pilot/safety-net-medical-home-initiative-0 • Describes the goal of developing and demonstrating a replicable and sustainable implementation model for medical home transformation
Describe the benefits of implementing PCMH	Recognize the overall benefits of implementing PCMH	http://www.pcpcc.net/guide/benefits-implementing-pcmh • Benefits of Implementing the Patient Centered Medical Home – Cost and Quality Results http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/PCMH_Defining%20the%20PCMH_v2 • Defines Patient-Centered Medical Home and explains why it is a preferred approach to healthcare
	Contrast the care provided by a personal clinician to the care received by a patient who does not have a medical home	http://www.pcpcc.net/sites/default/files/resources/Coordinating%20Care%20in%20the%20Medical%20Neighborhood%20%283%29.pdf Providers & Clinicians: Describes the difference between primary care clinicians and the PCMH model http://www.graham-center.org/online/etc/medialib/graham/documents/publications/mongraphs-books/2007/rgcmo-medical-home.Par.0001.File.tmp/rgcmo-medical-home.pdf • The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change: Provides evidence that is foundational to the PCMH concept and identifies key elements for delivering a patient-centered experience http://www.youtube.com/watch?v=vF5KFG03V_I • Video on the Wisconsin Academy of Family Physicians' Web site: Presents the experiences of two different patients — one who has a medical home and one who does not

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Discuss your role and the patient's role in PCMH	List the key patient actions and responsibilities to be an active patient in PCMH	http://www.ipfcc.org/pdf/GettingStarted-AmbulatoryCare.pdf • Advancing the Practice of Patient and Family Centered Care in Primary Care and other Ambulatory Setting: Includes checklists for patient actions and responsibilities
	Recognize the patient's perspective on PCMH	http://www.pcpcc.net/webinar/patients-members-medical-home-care-team • Webinar and slides: Patients as Members of the Medical Home Care Team http://www.ncqa.org/Portals/0/Programs/Recognition/PCMH_Overview_Apr01.pdf • Standards and Guidelines for Physician Practice Connections® Patient-Centered Medical Home, pg. 4 http://www.emmisolutions.com/medicalhome/transformed/english.html • Video: Introduction to Patient Centered Medical Home http://www.uhfnyc.org/assets/956 • The Patient-Centered Medical Home: Taking a Model to Scale in New York State: Describes the PCMH model's core elements and examines its effectiveness, particularly in improving the care of patients with chronic diseases, whom the current health care system serves least well, pg. 22
	Explore how your role engages with PCMH models	http://www.pcpcc.net/webinar/patients-members-medical-home-care-team • Webinar and slides: Patients as Members of the Medical Home Care Team *Patient Centered Medical Home Patient Engagement Workbook* ISBN: 978-1-56829-392-9
Recognize best practices for establishing a true PCMH	Consider a true PCMH health care setting and describe its characteristics	http://www.pcpcc.net/guide/benefits-implementing-primary-care-medical-home • Patient Centered Medical Home – Building Evidence and Momentum - A compilation of PCMH pilot and demonstration projects

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	Consider a true PCMH health care setting and describe its characteristics	http://www.pcpcc.net/sites/default/files/media/workforce_training_talk_for_pcpcc_education_taskforce_april_20_2010.pdf Workforce Training for PCMH: What are we doing to equip the team? Shows best-practice examples of establishing PCMH practices http://wwww.pcpcc.net/content/examples-successful-integrated-models • Examples of Successful Integrated Models: Includes examples and case studies
Recognize the importance of information systems in promoting PCMH	Describe the role of information systems in enhanced communication, shared decision making, and quality improvement	Agency for Health Care Research and Quality (AHRQ). 2008. National Healthcare Quality Report 2007.Rockville, MD: Agency for Healthcare Research and Quality. http://www.ncbi.nlm.nih.gov/books/NBK22857/ • Crossing the Quality Chasm: Provides examples of how information technology can improve quality of healthcare • Book: Institute of Medicine. 2001. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academies Press. http://www.ncbi.nlm.nih.gov/pubmed/16898981 • Creating high reliability in health care organizations: Presents a comprehensive approach to help health care organizations reliably deliver effective interventions • Book: Pronovost, P. J., S. M. Berenholtz, C. A. Goeschel, D. M. Needham, J. B. Sexton, D. A. Thompson, L. H. Lubomski, J. A. Marsteller, and M. A. Makary. 2006. ‘‘*Creating High Reliability in Healthcare Organizations*’’ Health Services Research 41 (4): 1599–617
Identify the information systems that support PCMH	List the types of information systems needed to support PCMH	http://www.tricare.mil/tma/ocmo/download/MHSPCMHGuide.pdf • Military Health System Patient Centered Medical Home Guide, chapter 6

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Define Meaningful Use (MU) and its connection to PCMH	Compare and contrast PCMH and MU criteria	https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage1vsStage2CompTablesforEP.pdf Comparison table for professionals http://www.pcdc.org/assets/pdf/pcmh-mu-alignment.pdf • Patient Centered Medical Home & Meaningful Use Criteria Crosswalk: Illustrates the relationship between PCMH and MU
	Explain that meaningful use of EHR and effective HIT is the information management infrastructure for powering the workflows in a PCMH and more broadly, systems of care	http://www.innovations.ahrq.gov/content.aspx?id=3048 Incorporating Health Information Technology Into Workflow Redesign: Provides information and tools to help small and medium-sized outpatient practices assess their workflows to implement health information technology (health IT)
Describe the importance of information systems in patient care	Define enhanced access and how it is supported through quality information systems	http://www.ihi.org/knowledge/Pages/ImprovementStories/OpenAccessatPrimaryCarePartners.aspx • Open Access at Primary Care Partners: Defines open access scheduling and its benefits http://www.aap.org/en-us/professional-resources/practice-support/quality-improvement/Pages/Quality-Improvement-Open-Access-Scheduling.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token • Quality Improvement: Open Access Scheduling: Defines and gives the benefits of open access scheduling http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2587225/ • Implementation of Open Access Scheduling in Primary Care: A Cautionary Tale: Assesses the impact of open access implementation and examines barriers to implementing this model

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	Describe the role of information systems in supporting key PCMH standards such as continuity of care, promoting self-care, and tracking and coordinating care	http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Evidence-Based-Care.pdf • Organized, Evidence-Based Care Implementation Guide: Examines three areas critical to the delivery of care that is well organized and evidence-based • Introduces a comprehensive toolkit developed specifically to assist practices with implementing the Chronic Care Model (CCM)
	Use an evidence-based approach for chronic disease management and preventive health care	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070776/ • Individualized stepped care of chronic illness: Provides evidence-based guidelines for diverse chronic conditions to identify elements of patient care http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Evidence-Based-Care.pdf • Organized, Evidence-Based Care Implementation Guide: Case Study: ISU Family Medicine Residency Uses Diabetes Care Template to Treat Diabetics, pg. 12
Identify the information systems for patient care	List the types of information systems needed for patient care	http://www.tricare.mil/tma/ocmo/download/MHSPCMHGuide.pdf • Military Health System Patient Centered Medical Home Guide, chapter 6
	Identify the specific information systems in your practice and how they support patient care	Recommendation: Develop learning activity by leveraging this resource: http://www.tricare.mil/tma/ocmo/download/MHSPCMHGuide.pdf • Military Health System Patient Centered Medical Home Guide, chapter 6
Identify and describe the importance of information systems for patient care outside of practice	Describe the use of information systems for sending orders, referrals, and prescriptions and the importance of tracking for follow-up or completion of requested services	http://www.pcpcc.net/sites/default/files/media/cehia_mc.pdf • Meaningful Connections – A resource guide for using health IT to support patient centered medical home: Provides guidance on how health IT can be effectively implemented to support key elements of the PCMH
Recognize shared decision making as a key component to PCMH	Discuss the importance of shared decision making between care team members and patients and their care team	http://www.pcpcc.net/video/care-coordination-and-patients-role-shared-decision-making-and-team-communication Webinar and Slides: Care Coordination and the Patient's Role in Shared Decision Making and Team Communication

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	Discuss the importance of shared decision making between care team members and patients and their care team	http://www.nejm.org/doi/full/10.1056/NEJMp1109283 • Shared Decision Making — The Pinnacle of Patient-Centered Care: Discusses the importance of shared decision making in PCMH http://shareddecisions.mayoclinic.org/blog-2/page/3/ • Video: Defines shared decision making and how to make it happen in reality
	Identify your role in shared decision making with patients	Recommendation: Develop learning activity by leveraging this resource: http://www.pcpcc.net/sites/default/files/media/pcpcc-_care_coord-7-12-12.pdf The Medical Home Experience: Care Coordination and the Patient's Role in Shared Decision Making and Team Communication
	List ways to implement shared decision making at the point of care and beyond	http://www.iom.edu/~/media/Files/Perspectives-Files/2012/Discussion-Papers/VSRT-Evidence.pdf • Communicating with Patients on Health Care Evidence: Presents findings on research around people's expectations and describes communication strategies and messages that are effective in raising awareness about—and driving demand for—high-quality, shared medical decisions
Know how to implement shared decision making	Identify the key actions necessary to implement shared decision making	http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Evidence-Based-Care.pdf • Organized, Evidence-Based Care Implementation Guide: Explains how decision support interventions increase the likelihood that care adheres to evidence-based guidelines, pg. 7 http://content.healthaffairs.org/content/32/2/268.abstract?=right • A Demonstration of Share Decision Making In Primary Care
Discuss the central role of teamwork in PCMH	Define what it is to be a team and how to provide team-based care	http://teamstepps.ahrq.gov/ • Describes TeamSTEPPS, which is a teamwork system designed for health care professionals that is an evidence-based teamwork system to improve communication and teamwork skills among health care professionals

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	Define what it is to be a team and how to provide team-based care	http://www.youtube.com/watch?v=Wttxm7jAnb4 • Video: Gives an example of a "huddle" involving physician and medical assistant designed to highlight, communicate and facilitate "planned care" elements of an office visit
	State the reasons why teamwork is important in PCMHs	http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingTeamsInPrimaryCareLessons.pdf • Building Teams in Primary Care: Lessons Learned: Features 15 winning teams in primary care that offer lessons to primary care practices and clinics trying to build teams http://www.aafp.org/online/en/home/membership/initiatives/pcmh/aafpleads/aafppcmh/pcmhvideos.html#Parsys52741 • Video: Improve Care with a Team-Based Model
	Distinguish between group work and team work	http://www.tricare.mil/tma/ocmo/download/MHSPCMHGuide.pdf • Military Health System Patient Centered Medical Home Guide, chapter 14
Describe the various roles and functions of team members in PCMH	Recognize the expanded team roles within a PCMH practice	http://www.tricare.mil/tma/ocmo/download/MHSPCMHGuide.pdf • Military Health System Patient Centered Medical Home Guide, chapter 5 http://www.pcpcc.net/webinar/taskforce-education-training-workforce-pcmh Workforce Training for PCMH: What are we doing to equip the team? Shows roles and responsibilities in PCMH practice
	Define provider-directed team-oriented practice (revised from physician-directed)	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2869425/ • Defining and Measuring the Patient-Centered Medical Home
	Link each role to the patient experience and outcomes	http://www.transformed.com/publications.cfm • Patient-Centered Medical Home Care Coordination Workbook: Provides an understanding of each team member's role and responsibility at the time of the patient interaction and a clearly defined flow of accurate information between team members

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	Identify the function of your specific role as a team member in PCMH	Recommendation: Develop learning activity leveraging this resource: http://www.pcpcc.net/webinar/taskforce-education-training-workforce-pcmh • Workforce Training for PCMH: What are we doing to equip the team? Shows roles and responsibilities in PCMH practice http://www.transformed.com/publications.cfm • Patient-Centered Medical Home Care Coordination Workbook: Provides an understanding of each team member's role and responsibility at the time of the patient interaction and a clearly defined flow of accurate information between team members
Develop high-functioning interdisciplinary teams	List the characteristics of high-functioning interdisciplinary teams	http://www.infed.org/thinkers/tuckman.htm • Describes Tuckman's model of team development, including the four stages of team development: forming, storming, norming and performing in groups http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-16-2011/No2-May-2011/Patient-Centered-Care-in-a-Medical-Home.html • Patient-Centered Care in a Medical Home: Provides an example of a practice implementing the PCMH model in which a proactive, multidisciplinary care team collectively takes responsibility for each patient
	Implement skills and activities for developing high-functioning interdisciplinary teams	http://www.infed.org/thinkers/tuckman.htm • Describes Tuckman's model of team development, including the four stages of team development: forming, storming, norming and performing in groups http://wwww.pcpcc.net/content/building-team-0 Build the Team: Transforming medical practice into a team approach to care that is a cornerstone of the PCMH
	Analyze and discuss effective team behaviors	http://www.youtube.com/watch?v=Wttxm7jAnb4 • Video: Gives an example of a "huddle" involving physician and medical assistant designed to highlight,

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		communicate and facilitate "planned care" elements of an office visit http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-16-2011/No2-May-2011/Patient-Centered-Care-in-a-Medical-Home.html • Patient-Centered Care in a Medical Home: Provides an example of a practice implementing the PCMH model in which a proactive, multidisciplinary care team collectively takes responsibility for each patient
	From employee prototypes and other information, build the ideal PCMH team	http://www.pcpcc.net/sites/default/files/media/workforce_training_talk_for_pcpcc_education_taskforce_april_20_2010.pdf Workforce Training for PCMH: What are we doing to equip the team? Provides characteristics of an ideal PCMH
	Identify obstacles to teamwork and list ways to overcome them	http://www.infed.org/thinkers/tuckman.htm • Describes Tuckman's model of team development, including the four stages of team development: forming, storming, norming and performing in groups
Promote cross-boundary cooperation and partnership among all provider types	Identify success factors for cross boundary cooperation	http://www.texmed.org/Template.aspx?id=24411 • Right Care, Right Person, Right Time, Right Place: Illustrates key roles and the information flow in the medical neighborhood
	Discuss skills to build cross boundary cooperation and partnerships	http://teamstepps.ahrq.gov/ • Describes TeamSTEPPS, which is a teamwork system designed for health care professionals that is an evidence-based teamwork system to improve communication and teamwork skills among health care professionals
Describe the role of effective communication in PCMH	Explain the importance of effective communication in PCMH	http://teamstepps.ahrq.gov/ • Describes TeamSTEPPS, which is a teamwork system designed for health care professionals that is an evidence-based teamwork system to improve communication and teamwork skills among health care professionals

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Identify ways to communicate with patients and team members	List effective modes of communication	http://occonline.occ.cccd.edu/online/klee/CommunicationsStyleInventory.pdf • Communications Style Inventory: An informal survey designed to determine how you usually act in everyday situations. Helps you get a clear description of how you see yourself http://teamstepps.ahrq.gov/ • Describes TeamSTEPPS, which is a teamwork system designed for health care professionals that is an evidence-based teamwork system to improve communication and teamwork skills among health care professionals http://www.jabfm.org/content/25/2/224.long • Implementing Teams in a Patient-centered Medical Home Residency Practice: Effective Communication: Outlines several structured processes for routine communication among the members of each team and among the entire practice group http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2928073/ • Seven Characteristics of Successful Work Relationships
	Describe a communication model for a systematic, relationship-centered approach to communicating with patients	https://www.studergroup.com/resources/news-media/publications/insights/june-2011/enhancing-communication-skills-for-physicians-beyo/ Provides a powerful communication tool called AIDET®. When interacting with patients, gaining trust is essential for obtaining patient compliance and improving clinical outcomes. AIDET is a simple acronym that represents how to gain this trust and communicate with people who are nervous, anxious, and feeling vulnerable. *AIDET® is a registered trademark of The Studer Group, LLC.* http://teamstepps.ahrq.gov/ • Describes TeamSTEPPS, which is a teamwork system designed for health care professionals that is an evidence-based teamwork system to improve communication and teamwork skills among health care professionals

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	List guidelines for email communication with patients	http://www.pcpcc.net/consumers-and-patients • Consumers & Patients: Discusses the use of secure email http://www.ncbi.nlm.nih.gov/pmc/articles/PMC61279/ • Guidelines for the Clinical Use of Electronic Mail with Patients
	Describe key touch points in patient communication such as first and ongoing contact	http://store.hin.com/Patient-Engagement-in-the-Patient-Centered-Medical-Home-A-Continuum-Approach-a-45-minute-webinar-on-August-22-2012-now-available-for-replay_p_4440.html • Webinar: Patient Engagement in the Patient-Centered Medical Home: A Continuum Approach: Discusses four key areas within a PCMH to engage consumers, including: consumer insight, technology, behavioral economics and outreach and communications (note: there is a fee for this webinar) http://towerstrategies.com/wp-content/uploads/2012/07/Patient-Engagement-and-Their-Experience-Whitepaper.pdf • Patient Engagement and Their Experience: The Virtual Touch Points: Defines the patient experience system-wide and across all patient touch points - physical and virtual
Demonstrate effective listening, observation and communication techniques	Demonstrate effective listening, observation and communication techniques in a role play situation	Recommendation: Develop learning activity by leveraging this resource: http://www.youtube.com/watch?v=iyivrUPbo3Q • Professional Behavior in Healthcare Professions: Effective Communication http://healthcarecomm.org/wp-content/uploads/2011/05/Tongue-2005-.pdf • Communication Skills for Patient-Centered Care: Describes communication techniques that benefit surgeons and their patients http://www.ais.up.ac.za/health/blocks/blocksa1/invite.pdf Invite, Listen, and Summarize: A Patient-Centered Communication Technique: Describes a communication method

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		That emphasizes techniques of open-ended inquiry, empathy, and engagement to gather data
Overcome barriers to effective communication	Recognize ways to overcome communication barriers	http://occonline.occ.cccd.edu/online/klee/CommunicationsStyleInventory.pdf • Communications Style Inventory: An informal survey designed to determine how you usually act in everyday situations. Helps you get a clear description of how you see yourself.
Explain the strategy for developing effective patient partnerships	Discuss the importance and benefits of engaging patients, pre-, during and post-visit	http://forces4quality.org/b/45/consumer-engagement-#featured-resource • Consumer Engagement: Provides resources for enhancing patient engagement in PCMH
Develop effective patient partnerships as a key component of PCMH	Describe the role of each team member in developing effective patient partnerships	http://forces4quality.org/b/45/consumer-engagement-#featured-resource • Consumer Engagement: Provides resources for enhancing patient engagement in PCMH http://www.medscape.com/viewarticle/760343_4 • Implementing Teams in a Patient-centered Medical Home Residency Practice: Effective Communication: Outlines several structured processes for routine communication among the members of each team and among the entire practice group
	Recognize the role of patient representatives serving at the practice level	http://forces4quality.org/b/45/consumer-engagement-#featured-resource • Consumer Engagement: Provides resources for enhancing patient engagement in PCMH http://www.healthteamworks.org/blog/Practices-in-Transformation/Integrating-Care-Coordination-into-the-PCMH-Practice.html • Integrating Care Coordination into the PCMH Practice: Gives an example of a PCNH practice that hired a care coordinator
	List key actions for developing effective patient partnerships	http://forces4quality.org/b/45/consumer-engagement-#featured-resource • Consumer Engagement: Provides resources for enhancing patient engagement in PCMH

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	Serve as the patients' advocate for their health care needs and resources within the practice and the health care system	http://forces4quality.org/b/45/consumer-engagement-#featured-resource • Consumer Engagement: Provides resources for enhancing patient engagement in PCMH
Facilitate continuity of care to meet patients' needs in a timely and agreeable manner	Describe approaches to improving the continuity of outpatient care as patients transition between the medical home and other points of care, e.g., specialists, hospitals, etc.	http://pcmh.ahrq.gov • Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms, pg. 19
	Identify methods to increase the continuity of patients' care within the medical home	http://www.youtube.com/watch?v=Wttxm7jAnb4 • Video: Gives an example of a "huddle" involving physician and medical assistant designed to highlight, communicate and facilitate "planned care" elements of an office visit
	Discuss approaches to improving continuity as patients transition across other sites of care	http://www.caretransitions.org/documents/The%20CTI%20-%20HHCSQ.pdf • The Care Transitions Intervention: A Patient-Centered Approach to Ensuring Effective Transfers Between Sites of Geriatric Care: Introduces a patient-centered interdisciplinary team intervention designed to improve transitions across sites of geriatric care
Discuss effective examples of patient partnerships	Examine and explain a case where a patient having a personal clinician improved their care by avoiding an ER visit, a re-admission or unnecessary admission, unneeded tests, or unnecessary procedures	Recommendation: Develop case study by leveraging this resource: http://www.foma.org/assets/Convention2013/Friday/Patient%20Centered%20Medical%20Home%20Delo.pdf • Meaningful Use (MU) and The Patient Centered Medical Home (PCMH): Provides research results of PCMHs including reduced ER visits, hospitalizations and inpatient admissions
	List ways you can develop effective patient partnerships specific to your role	Recommendation: Develop learning activity by leveraging this resource: http://www.safetynetmedicalhome.org/change-concepts/patient-centered-interactions • Patient-Centered Interactions: Lists resources for implementing patient-centered interactions
Manage resistance or conflict within the patient partnership	Identify ways to overcome resistance or obstacles to effective patient partnerships	http://www.vitalsmarts.com • Crucial Conversations: Technique that creates alignment and agreement by fostering open dialogue around high-stakes topics

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		http://forces4quality.org/paving-way-difficult-conversations?term_id=45 • Paving the Way for Difficult Conversations: A patient engagement program focused on palliative care to help patients with life-limiting diseases receive the care they want
	Work with other team members to identify specific practices used to manage patient resistance or conflict effectively	http://www.vitalsmarts.com • Crucial Conversations: Technique that creates alignment and agreement by fostering open dialogue around high-stakes topics http://forces4quality.org/paving-way-difficult-conversations?term_id=45 • Paving the Way for Difficult Conversations: A patient engagement program focused on palliative care to help patients with life-limiting diseases receive the care they want
Define care coordination as a key strategy for PCMH	List the potential improvements resulting from effective care coordination	http://archive.pcpcc.net/files/webinar/pcpcc-implementing_care_coord_may-17th-2012.pdf • Webinar and slides: Reviews care coordination models and effective implementation practices http://www.pcpcc.net/webinar/care-coordination-expanding-team-healthcare-community • Webinar: Care Coordination: Expanding the Team to the Healthcare Community: Describes one practice's team approach to care coordination within the community and their focus on patient centered care across delivery systems that supported effective Care Coordination

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Recognize the importance of integrated, coordinated care in successful health care outcomes	Discuss the importance of integrated care across multiple co-morbid chronic illnesses, acute complaints, mental health, prevention and family care	http://www.improvingchroniccare.org/index.php?p=Planned_Care&s=30 • Planned Care Visit: Demonstrates how health care teams implement innovations in care for people who live with chronic illness http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070776/ • Individualized stepped care of chronic illness: Provides evidence-based guidelines for diverse chronic conditions to identify elements of patient care http://www.mendeley.com/research/evidence-based-guideline-improving-medication-management-older-adult-clients/ • Evidence-based guideline: Improving medication management for older adult clients: Provides assessments and interventions for managing medications that are useful across settings
Implement coordinated care	Recognize strategies to coordinate complex care needs	http://www.annfammed.org/content/10/1/60.full • Organizing Care for Complex Patients in the Patient-Centered Medical Home: Summarizes work by the Agency for Healthcare Research & Quality and Mathematica Policy Research on policies and strategies to help typical, smaller primary care practices transform into effective medical homes that appropriately serve patients with complex needs
	Provide examples of successful approaches to care coordination	http://www.pcpcc.net/webinar/implementing-care-coordination-within-pcmh-model • Webinar: Reviews care coordination models and effective implementation practices http://www.pcpcc.net/webinar/care-coordination-expanding-team-healthcare-community • Webinar: Describes a team approach to care coordination within the community http://archive.pcpcc.net/files/carecoordination_pcpcc.pdf Care Coordination Guide: Offers insight into what is known and tested about care coordination, and is designed to

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		offer a roadmap for new and emerging programs • Provides case examples that represent a range of programs at various stages in the journey http://www.pcpcc.net/webinar/care-coordination-expanding-team-healthcare-community • Webinar: Care Coordination: Expanding the Team to the Healthcare Community: Describes one practice's team approach to care coordination within the community and their focus on patient centered care across delivery systems that supported effective Care Coordination
	Follow-up on referrals, labs, x-rays, and other patient services (role specific)	http://www.tricare.mil/tma/ocmo/download/MHSPCMHGuide.pdf • Military Health System Patient Centered Medical Home Guide, chapter 4
	Manage mental and behavioral issues for patients in collaboration with mental/behavioral health care providers in the practice and/or community (role specific)	http://www.tricare.mil/tma/ocmo/download/MHSPCMHGuide.pdf • Military Health System Patient Centered Medical Home Guide, chapter 4 http://www.pcpcc.net/behavioral-health • Special Interest Group on Behavioral Health: Provides resources for the integration of behavioral health, medication management, and other services in the PCMH
Use health information systems to coordinate patient care	Recognize the key points in patient care to use information systems for care coordination	http://www.piperreport.com/blog/2012/04/17/health-care-coordination-role-health-information-technology-care-coordination/ • Health IT and Care Coordination: Role of Health Information Technology in Care Coordination: Describes ways public and private sectors can use health IT infrastructure to support care coordination and explores the functions and qualities required to achieve this vision http://www.healthit.gov/policy-researchers-implementers/beacon-community-program • Health IT Adoption Programs: Beacon Community Program: Demonstrates how health IT investments and Meaningful Use of electronic health records (EHR) advance the vision of patient-centered care, while achieving the three-part aim of better health, better care at lower cost.

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Discuss the role of evidence-based care in PCMH	Define the central role of evidence-based care to PCMH	http://www.safetynetmedicalhome.org/change-concepts/organized-evidence-based-care • Defines organized, evidence-based care and lists evidence-based care resources http://www.tricare.mil/tma/ocmo/download/MHSPCMHGuide.pdf • Military Health System Patient Centered Medical Home Guide, p.13
	Recognize how evidence-based medicine and decision-support tools guide decision making	http://www.elsevierhealth.com/media/us/samplechapters/9780750688857/9780750688857.pdf • Reports on research that examines the context of and factors influencing clinical decision making
Improve patient outcomes by utilization of information systems in patient care	Identify resources for decision-supports and evidence based guidelines	http://www.pcpcc.net/evaluation-evidence • Improving Quality & Outcomes : Lists key features of a medical home that help improve the experience of care http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/PCMH_Tools%20&%20Resources_Patient-Centered_v2 • PCMH Resource Center: Provides resources for improving patient outcomes http://www.aafp.org/online/en/home/membership/initiatives/pcmh/aafpleads/aafppcmh/pcmhvideos.html#Parsys52741 • Video: Use Data to Improve Your Practice
Quality Standards		
Discuss the roles and responsibilities in maintaining quality improvement	Identify your role and responsibilities, and those of others on your team, to maintain quality improvement	Recommendation: Develop learning activity by leveraging this resource: http://www.tricare.mil/tma/ocmo/download/MHSPCMHGuide.pdf • Military Health System Patient Centered Medical Home Guide, chapter 5

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	Identify your role and responsibilities, and those of others on your team, to maintain quality improvement	http://www.jabfm.org/content/25/2/224.long • Implementing Teams in a Patient-Centered Medical Home Residency Practice: Lessons Learned: Reports challenges and successes in the transformational journey to a patient-centered medical home, for which a team approach is critical to achieving high quality care
	Identify and discuss how to relate to team behaviors that strengthen or weaken patient safety and quality of care	http://www.ncbi.nlm.nih.gov/books/NBK2682/ • Tools and Strategies for Quality Improvement and Patient Safety: Discusses various process-improvement techniques to identify inefficiencies, ineffective care, and preventable errors to then influence changes associated with systems
Work as a team to maintain quality improvement	List responsibilities necessary to function as a team in quality improvement	http://www.jabfm.org/content/25/2/224.long • Implementing Teams in a Patient-Centered Medical Home Residency Practice: Lessons Learned: Reports challenges and successes in the transformational journey to a patient-centered medical home, for which a team approach is critical to achieving high quality care
	List your specific tasks that contribute to quality improvement in your practice	Recommendation: Develop learning activity by leveraging this resource: http://www.transformed.com/transformed.cfm • The TransforMED Patient-Centered Model: Unites the enduring relationship-centered values of primary practice with new technologies and approaches to enable practices to better serve the needs of both patients and practices
	Using an example, illustrate the role and responsibilities of a quality improvement team	Recommendation: Develop learning activity by leveraging this resource: http://www.jabfm.org/content/25/2/224.long • Implementing Teams in a Patient-Centered Medical Home Residency Practice: Lessons Learned: Reports challenges and successes in the transformational journey to a patient-centered medical home, for which a team approach is critical to achieving high quality care

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Engage in a formal process of quality improvement focusing on both service and clinical outcome measures	Recognize a formal quality improvement process	http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-QI-Strategy-1.pdf • Quality Improvement Strategy: Choosing and Using a QI Framework: Provides information on the QI strategies most often used in the primary care setting for PCMH transformation, which are the Model for Improvement and Lean Methods
	Discuss best practices of successful teamwork in quality improvement	http://www.ncbi.nlm.nih.gov/books/NBK2682/ • Tools and Strategies for Quality Improvement and Patient Safety: Discusses various process-improvement techniques to identify inefficiencies, ineffective care, and preventable errors to then influence changes associated with systems
	Identify a patient safety issue in the practice and design a program to address this issue	Recommendation: Develop learning activity by leveraging this resource: http://www.pcpcc.net/sites/default/files/media/medmanagement.pdf Integrating Comprehensive Medication Management to Optimize Patient Outcomes: Provides a framework for integrating comprehensive medication management within the PCMH as part of the practice redesign that needs to occur when individual and group practices transform into the PCMH
Identify workflow and data collection issues from a clinical perspective, including quality measurement and improvement	Given a scenario, identify workflow and data collection improvements for the practice	Recommendation: Develop scenario by leveraging these resources: http://www.innovations.ahrq.gov/content.aspx?id=3048 • Incorporating Health Information Technology Into Workflow Redesign: Provides information and tools to help small and medium-sized outpatient practices assess their workflows to implement health information technology (health IT) http://clinicalmicrosystem.org/materials/materials_overview/ • Clinical Microsystems: Lists resources related to clinical microsystems

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	Create a plan for addressing workflow and data collection improvements based on the given scenario	Recommendation: Develop learning activity by leveraging this resource: http://nyehealth.org/wp-content/uploads/2012/07/NYeC-Intake-and-Registration-Guidance.pdf • Workflow Optimization Intake Process: Guides a practice in the transition of the intake process workflow from a paper-based operation to one that includes the use of an electronic health record (EHR)
Identify processes and information flows that accommodate quality improvement and reporting	Given a scenario, identify processes and information flows that accommodate quality improvement and reporting	Recommendation: Develop learning activity by leveraging these resources: http://www.innovations.ahrq.gov/content.aspx?id=3048 • Incorporating Health Information Technology Into Workflow Redesign: Provides information and tools to help small and medium-sized outpatient practices assess their workflows to implement health information technology (health IT) http://www2.inbox.com/search/results1.aspx?qkw=clinical+microsystems+the+green+book&tbid=80274&tp=bs&lng=en • Clinical Microsystems: Lists resources related to clinical microsystems *What Works: Effective Tools and Case Studies to Improve Clinical Office Practice* ISBN-10: 0970718713 | ISBN-13: 978-0970718716

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Discuss key strategies for improving patient care	Participate in practice improvement meetings and work with other students to discuss key QI strategies	Recommendation: Develop learning activity by leveraging these resources: http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-QI-Strategy-1.pdf • Quality Improvement Strategy: Choosing and Using a QI Framework: Provides information on the QI strategies most often used in the primary care setting for PCMH transformation, which are the Model for Improvement and Lean Methods http://www.jabfm.org/content/25/2/224.long • Implementing Teams in a Patient-Centered Medical Home Residency Practice: Lessons Learned: Reports challenges and successes in the transformational journey to a patient-centered medical home, for which a team approach is critical to achieving high quality care
	Analyze patient quality and safety data concerning a common condition seen in the practice	Recommendation: Develop learning activity by leveraging this resource: http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/PCMH_Home_Papers%20Briefs%20and%20Othe%20Resources_v2 • PCMH Resource Center: Includes resources on quality and safety data
Improve patient outcomes by using quality healthcare data in patient care	Describe the role of electronic medical records, decision supports, and data collection in quality improvement measures	http://www.aap.org/en-us/professional-resources/practice-support/quality-improvement/Pages/Quality-Improvement-Open-Access-Scheduling.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token • Quality Improvement: Open Access Scheduling: Defines and gives the benefits of open access scheduling http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2587225/ • Implementation of Open Access Scheduling in Primary Care: A Cautionary Tale: Assesses the impact of open access implementation and examines barriers to implementing this model

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		http://www.healthit.gov/providers-professionals/improved-diagnostics-patient-outcomes • Improved Diagnostics & Patient Outcomes: Describes the use of Electronic health records (EHRs) to improve the ability to diagnose diseases and reduce—even prevent—medical errors, improving patient outcomes
	List best practices for ensuring quality healthcare data	*What Works: Effective Tools and Case Studies to Improve Clinical Office Practice* ISBN-10: 0970718713 | ISBN-13: 978-0970718716
Describe the connection between meaningful use and PCMH	Describe the coordination of efforts to systematically input accurate patient data into the EMR and export meaningful reports from this data	http://www.healthit.gov/providers-professionals/improved-diagnostics-patient-outcomes • Improved Diagnostics & Patient Outcomes: Describes the use of Electronic health records (EHRs) to improve the ability to diagnose diseases and reduce—even prevent—medical errors, improving patient outcomes
Collect and use data for population management	Discuss best practices for collecting and using data to manage patient populations	http://www.transformed.com/publications.cfm • Publications and Workbooks by TransforMED: Patient-Centered Medical Home Access Workbook: Simplifies decision making and provides tips to successfully implementing elements of patient-centered access that are key to successful population management
Describe the importance of clinical decision making in quality standards for PCMH	Define clinical decision making	http://www.elsevierhealth.com/media/us/samplechapters/9780750688857/9780750688857.pdf • Reports on research that examines the context of and factors influencing clinical decision making http://www.healthit.gov/policy-researchers-implementers/clinical-decision-support-cds • Clinical Decision Support (CDS): Defines clinical decision support and why it is important
	Recognize how clinical decision-support tools guide decision-making	http://www.healthit.gov/policy-researchers-implementers/clinical-decision-support-cds • Clinical Decision Support (CDS): Defines clinical decision support and why it is important http://www.clinicaldecisionsupport.com/fullpanel/uploads/files/elsevier-clinical-decision-support-impacting-the-cost-and-quality-wp-4web-00001-00001.pdf • Elsevier Clinical Decision Support: Impacting the Cost and Quality of Healthcare: Explains that Clinical Decision Support is a critical component for organizations seeking to improve the health of the healthcare delivery system

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	Following a question template, apply clinical decision-making skills to a case study	Recommendation: Develop learning activity by leveraging this resource, which includes a question template: http://meded.ucsd.edu/clinicalmed/thinking.htm • A Practical Guide to Clinical Medicine: Defines clinical decision making and incorporates a series of questions in a step-wise fashion http://www.clinicaldecisionsupport.com/fullpanel/uploads/files/elsevier-clinical-decision-support-impacting-the-cost-and-quality-wp-4web-00001-00001.pdf • Elsevier Clinical Decision Support: Impacting the Cost and Quality of Healthcare: Explains that Clinical Decision Support is a critical component for organizations seeking to improve the health of the healthcare delivery system
Recognize the role of EHR in clinical decision making	Describe the use of an electronic health record (EHR) as an evidence-based decision-making tool	http://www.healthit.gov/providers-professionals/improved-diagnostics-patient-outcomes • Improved Diagnostics & Patient Outcomes: Describes the use of Electronic health records (EHRs) to improve the ability to diagnose diseases and reduce—even prevent—medical errors, improving patient outcomes http://coresolutionsinc.com/UsabilityWhitepaper.pdf • The Importance of Usability in Electronic Health Records: Provides an in-depth understanding of the process involved with developing a sound EHR user interface • Discusses fundamental design principles, providing end-users with important knowledge about how EHR systems should be structured
	Discuss which decision-making tools will be used in your practice	http://ebn.bmj.com/content/7/3/68.full • Explores why it is necessary to consider the clinical decision making context when examining the ways in which nurses engage with research based information • Considers the relation between the accessibility and usefulness of information from different sources and the decisions to which such information is applied.

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Provide evidence for improved outcomes	Seek research that provides evidence for improved outcomes	http://www.ahrq.gov/research/transpcaw.htm • Transforming Primary Care Practice: Describes grant applicants that demonstrated that their primary care practices underwent transformation to PCMHs for at least 1 year and have documented evidence that the transformation was successful http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/PCMH_Home_Papers%20Briefs%20and%20Othe%20Resources_v2 • Patient Centered Medical Home Resource Center: Lists briefs, papers, and resources that include evidence for improved outcomes in PCMH
	Describe the use of electronic health records in research to develop evidence-based guidelines	http://www.tricare.mil/tma/ocmo/download/MHSPCMHGuide.pdf • Military Health System Patient Centered Medical Home Guide, chapter 6
Use evidence-based guidelines for preventive, acute and chronic care management, including medication management	Describe evidence-based guidelines in various situations including preventive, acute and chronic care management	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070776/ • Individualized stepped care of chronic illness: Provides evidence-based guidelines for diverse chronic conditions to identify elements of patient care http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Evidence-Based-Care.pdf • Organized, Evidence-Based Care Implementation Guide: Introduces a comprehensive toolkit developed specifically to assist practices with implementing the Chronic Care Model (CCM)
Translate evidence-based guidelines into executable actions	Use examples to translate several evidence-based guidelines into executable actions	http://content.healthaffairs.org/content/20/6/64.long • Improving Chronic Illness Care: Translating Evidence Into Action: Describes the Chronic Care Model, its use in intensive quality improvement activities with more than 100 health care organizations, and insights gained in the process

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Recognize the importance and responsibility of following all HIPAA guidelines and regulations	Discuss the goals and purpose of HIPPA guidelines and regulations	Recommendation: Develop learning activity by leveraging this resource: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html • Summary of the HIPAA Privacy Rule: Summarizes key elements of the Privacy Rule including who is covered, what information is protected, and how protected health information can be used and disclosed
	Review HIPPA guidelines and regulations, and apply them to PCMH	http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html • Summary of the HIPAA Privacy Rule: Summarizes key elements of the Privacy Rule including who is covered, what information is protected, and how protected health information can be used and disclosed
Security and Privacy		
Maintain HIPAA compliance related to member records, member interaction and system access	Identify actions that maintain HIPPA compliance in a variety of real-world scenarios related to member records, member interaction and system access	http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html • Summary of the HIPAA Privacy Rule: Summarizes key elements of the Privacy Rule including who is covered, what information is protected, and how protected health information can be used and disclosed
Describe the purpose of HITECH	Define HITECH and its role in data privacy	http://www.hhs.gov/ocr/privacy/hipaa/administrative/enforcementrule/hitechenforcementifr.html • HITECH Act Enforcement Interim Final Rule: Defines the Health Information Technology for Economic and Clinical Health (HITECH) Act
Identify strategies ensuring HITECH supports PCMH	Read a brief and discuss the ways in which HITECH ensures EHRs are implemented in a way that supports primary care transformation	Recommendation: Develop learning activity leveraging this site: http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/PCMH_Home_Papers%20Briefs%20and%20Othe%20Resources_v2 • Patient Centered Medical Home Resource Center: Lists briefs, papers, and resources developed for various stakeholders interested in learning more about the medical home

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Identify effective security practices within your practice	Identify actions that adhere to good security practices in a variety of real-world scenarios	Recommendation: Develop scenarios leveraging this resource: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html • Summary of the HIPAA Privacy Rule: Summarizes key elements of the Privacy Rule including who is covered, what information is protected, and how protected health information can be used and disclosed
	Discuss your practice's guidelines for controlling access to protected health information	Recommendation: Leverage this resource to develop learning activity: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html • Summary of the HIPAA Privacy Rule: Summarizes key elements of the Privacy Rule including who is covered, what information is protected, and how protected health information can be used and disclosed
Discuss actions to take when data privacy/exchange has been compromised	Identify actions to take when data privacy/exchange has been compromised in a variety of real-world scenarios	http://www.healthit.gov/buzz-blog/privacy-and-security-of-ehrs/privacy-security-electronic-health-records/ • Privacy, Security, and Electronic Health Records: Responds to questions and concerns about the privacy and security of health information
Describe the importance of computer/EHR skills in data privacy	Discuss the role of effective computer/EHR skills in data privacy/exchange	http://csrc.nist.gov/news_events/hiipaa_june2012/day1/day1-b2_drode_integrity-protections.pdf • Data Integrity in an Era of EHRs, HIEs, and HIPAA: A Health Information Management Perspective: Defines and discusses data integrity
Follow EHR security and privacy practices through effective computer/EHR skills	Self-assess your computer/EHR skills and identify areas for improvement	Technical Skills Resources\1.1Computer_Skills_Survey.doc • Computer skills inventory
	Develop a plan for improving your computer/EHR skills	Recommendation: Develop action plan by leveraging this resource: Technical Skills Resources\1.1Computer_Skills_Survey.doc • Computer skills inventory
Team-Based Care		

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Conduct real-time problem-solving for successful outcomes	Review scenarios and discuss key problem-solving skills	http://www.mindtools.com/pages/article/newTMC_00.htm • Introduction to Problem Solving Skills: Describes four basic steps in problem solving
	Identify problem-solving skills in various team members	http://www.edpsycinteractive.org/papers/prbsmbti.html • Problem Solving and Decision Making: Consideration of Individual Differences: Presents research on personality and cognitive styles that identifies important individual differences in how people approach and solve problems and make decisions
	Discuss ways to implement problem-solving skills in your work	http://www.mindtools.com/pages/main/newMN_TMC.htm • Provides tools and techniques that help deal with problems that might otherwise seem huge, overwhelming, or excessively complex http://www.mindtools.com/pages/article/newTMC_00.htm • Introduction to Problem Solving Skills: Describes four basic steps in problem solving http://www.edpsycinteractive.org/papers/prbsmbti.html • Problem Solving and Decision Making: Consideration of Individual Differences: Presents research on personality and cognitive styles that identifies important individual differences in how people approach and solve problems and make decisions
Define leadership	Distinguish facilitative from authoritarian leadership	http://www.businessballs.com/leadership-theories.htm • Describes various leadership styles and theories

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	Identify behavioral attributes of effective medical leaders	http://www.youtube.com/watch?v=Wttxm7jAnb4 • Video: Gives an example of a "huddle" involving physician and medical assistant designed to highlight, communicate and facilitate "planned care" elements of an office visit http://instituteforbehavioralhealthintegration.org/media/9626/engaged_leadership.pdf • Strategies for Guiding PCMH Transformation from Within: Uses a framework to explain the areas in which leaders can most effectively use their time and energies to drive and sustain transformation
	Identify your responsibilities as a leader in team-based care	http://instituteforbehavioralhealthintegration.org/media/9626/engaged_leadership.pdf • Strategies for Guiding PCMH Transformation from Within: Uses a framework to explain the areas in which leaders can most effectively use their time and energies to drive and sustain transformation
Interact respectfully with all members of the health care team	Demonstrate the following communication skills: active listening, reflection, clarification, summation and empathy	Recommendation: Develop learning activity by leveraging this resource: http://www.health.vic.gov.au/qualitycouncil/downloads/communication_paper_120710.pdf • Promoting effective communication among healthcare professionals to improve patient safety and quality of care: Highlights the critical importance of, and common barriers to, effective communication in healthcare organizations and institutions, and points to some strategies and tools available to promote effective communication among healthcare professionals
Use leadership styles appropriate to various situations	Discuss the appropriate situations for the use of various leadership styles (e.g., democratic, directive, or situational - telling, selling, participating, delegating)	http://www.businessballs.com/slanalysis.htm • Presents situational leadership model http://www.eiconsortium.org • Summarizes the latest research in the area of emotional intelligence in the workplace

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	Discuss effective leadership styles you have observed in various team meetings and in team members	Recommendation: Develop learning activity by leveraging this resource: http://instituteforbehavioralhealthintegration.org/media/9626/engaged_leadership.pdf • Strategies for Guiding PCMH Transformation from Within: Uses a framework to explain the areas in which leaders can most effectively use their time and energies to drive and sustain transformation
Build effective and sustainable teams through leadership skills	Identify key elements for building effective and sustainable teams Identify key elements for building effective and sustainable teams	http://www.mindtools.com/pages/article/newTMM_95.htm • Shows how to create team charters, which are documents that define the purpose of the team, how it will work, and what the expected outcomes are http://www.mindtools.com/pages/main/newMN_TMM.htm • Teaches more than 120 team management skills • Provides the information and training needed to be a great team manager www.tablegroup.com/dysfunctions/ • Provides practical information for building teams through a universally embraced model http://teamstepps.ahrq.gov/ • Describes TeamSTEPPS, which is a teamwork system designed for health care professionals that is an evidence-based teamwork system to improve communication and teamwork skills among health care professionals http://wwww.pcpcc.net/content/building-team-0Build the Team • Transforming medical practice into a team approach to care that is a cornerstone of the PCMH
Lead effective team meetings	Identify steps for leading effective team meetings including clinical operations and practice improvement meetings	http://www.aafp.org/fpm/2007/1100/p35.html • Provides pointers to make sure team meetings are necessary and productive http://transformed.com/workingPapers/EffectiveMeetings.pdf • Making Meetings Effective: Helps hone the skill of managing regular, productive meetings

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		http://www.mindtools.com/pages/article/newTED_07.htm • Describes how to use a technique in meetings to block confrontations that happen when people with different thinking styles discuss the same problem
Be accountable as a PCMH team member	Identify your responsibilities as a PCMH team member and ways to hold yourself accountable	Recommendation: Develop learning activity by leveraging these resources: http://www.tricare.mil/tma/ocmo/download/MHSPCMHGuide.pdf • Military Health System Patient Centered Medical Home Guide, chapter 5 http://www.transformed.com/publications.cfm • Publications and Workbooks by TransforMED: Lists workbooks related to roles and responsibilities in PCMH transformation
	Identify your responsibilities as a PCMH team member and ways to hold yourself accountable	http://www.pcpcc.net/webinar/accountability-medical-neighborhood-perspectives-employers-and-providers • Accountability in the Medical Neighborhood: Perspectives from Employers and Providers
Promote mutual accountability among the team and between the team and patients	Review and discuss how to promote accountability in various situations	Recommendation: Develop learning activity by leveraging this resource: http://www.transformed.com/publications.cfm • Publications and Workbooks by TransforMED: Lists workbooks related to roles and responsibilities in PCMH transformation
Differentiate teamwork from group work	Define teamwork and group work	http://www.excellerate.co.nz/ttgroupsvsteams.html • Team Tactics: The Critical Difference between Groups and Teams: Explains the fundamental differences between work groups and real teams
	Distinguish characteristics and goals of teamwork from group work	http://www.excellerate.co.nz/ttgroupsvsteams.html • Team Tactics: The Critical Difference between Groups and Teams: Explains the fundamental differences between work groups and real teams

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	Distinguish characteristics and goals of teamwork from group work	http://www.aafp.org/online/en/home/membership/initiatives/pcmh/aafpleads/aafppcmh/pcmhvideos.html#Parsys52741 • Video: Improve Care with a Team-Based Model
	Provide examples of teamwork and group work	http://www.youtube.com/watch?v=Wttxm7jAnb4 • Video: Gives an example of a "huddle" involving physician and medical assistant designed to highlight, communicate and facilitate "planned care" elements of an office visit http://www.pcpcc.net/webinar/care-coordination-expanding-team-healthcare-community • Webinar: Care Coordination: Expanding the Team to the Healthcare Community: Describes one practice's team approach to care coordination within the community and their focus on patient centered care across delivery systems that supported effective Care Coordination
Describe effective communication with team members and external entities	Identify principles of effective communication with members of the office staff to plan and execute improvements in work processes	http://www.mindtools.com/page8.html • Provides links to over 75 articles that teach effective communication skills • Explores how you can communicate successfully in the many different situations you'll encounter in the workplace http://www.youtube.com/watch?v=Wttxm7jAnb4 • Video: Gives an example of a "huddle" involving physician and medical assistant designed to highlight, communicate and facilitate "planned care" elements of an office visit
Change Management		
Implement a change management model	Review a change management model and principles, and discuss how they can be implemented	http://www.mindtools.com/pages/article/newPPM_82.htm • Kotter's 8-Step Change Model: Introduces Kotter's eight-step change process •

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	Review a change management model and principles, and discuss how they can be implemented	http://www.improvingchroniccare.org/index.php?p=The_Model_Talk&s=27 • Clinical Practice Change: Includes survey tools for both team members and patients, a manual that presents concrete steps for change ordered sequentially, a toolkit for implementing the Chronic Care Model in safety net practices, and an assortment of aids to help in the challenging but critical work of transforming a practice to deliver CCM-based care http://instituteforbehavioralhealthintegration.org/media/9626/engaged_leadership.pdf • Strategies for Guiding PCMH Transformation from Within: Uses the Institute for Healthcare Improvement's (IHI) Seven Leadership Leverage Points for Organization-Level Improvement in Health Care framework to explain the areas in which leaders can most effectively use their time and energies to drive and sustain transformation
	Discuss case studies illustrating leadership for change and improvement	Recommendation: Develop learning activity by leveraging this resource: http://instituteforbehavioralhealthintegration.org/media/9626/engaged_leadership.pdf • Strategies for Guiding PCMH Transformation from Within: Uses the Institute for Healthcare Improvement's (IHI) Seven Leadership Leverage Points for Organization-Level Improvement in Health Care framework to explain the areas in which leaders can most effectively use their time and energies to drive and sustain transformation
	List best practices in leadership for change and improvement	http://instituteforbehavioralhealthintegration.org/media/9626/engaged_leadership.pdf • Strategies for Guiding PCMH Transformation from Within: Uses the Institute for Healthcare Improvement's (IHI) Seven Leadership Leverage Points for Organization-Level Improvement in Health Care framework to explain the areas in which leaders can most effectively use their time and energies to drive and sustain transformation
Describe the process of change management	Identify the key steps in change management	http://www.pcpcc.net/webinar/taskforce-education-training-workforce-pcmh • Webinar slides: Workforce Training for PCMH; illustrates stages of change http://www.leadership-and-motivation-training.com/managing-resistance-to-change.html • Managing Resistance To Change: Describes the five steps in the change process

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	Discuss change concepts: laying the foundation, building relationships, changing care delivery and reducing barriers	http://www.leadership-and-motivation-training.com/managing-resistance-to-change.html • Managing Resistance To Change: Describes the five steps in the change process
	List the key actions within each of the change concepts	http://www.leadership-and-motivation-training.com/managing-resistance-to-change.html • Managing Resistance To Change: Describes the five steps in the change process
Use change management knowledge to prepare the practice for transformation to PCMH	Apply a change management model to a real transformation situation and discuss the process	Recommendation: Develop situation by leveraging this resource: http://www.transformed.com/publications.cfm • Publications and Workbooks by TransforMED: Provides information on how to transform a practice into a high-performing patient-centered medical home • Provides concise, step-by-step information on relevant topics in health care delivery
Discuss the effect of the PCMH model on patient and practice outcomes	List the key outcomes from transitioning to the PCMH model	http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Feb/Guiding-Transformation.aspx • Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes: Outlines and describes the changes that most medical practices would need to make to become patient-centered medical homes www.clinical**microsystem**.org/ • Clinical Microsytems
Design the change initiative to achieve expected PCMH outcomes	List your actions in the transition process that will help achieve the expected PCMH outcomes	http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Feb/Guiding-Transformation.aspx • Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes: Outlines and describes the changes that most medical practices would need to make to become patient-centered medical homes

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Apply project management and change management principles to create implementation project plans to achieve the project goals	Given a scenario, create an implementation plan by applying project management and change management concepts	Recommendation: Develop scenario and learning activity by leveraging this resource: http://www.aafp.org/news-now/practice-professional-issues/20120613pcmhmakeover3.html • Building on Successful Patient-Centered Medical Home Transformation: Provides an example of implementation to a PCMH
Describe the roles and responsibilities in implementing the change	Match the key change management responsibilities to each team member role	http://www.transformed.com/publications.cfm • Publications and Workbooks by TransforMED: Lists workbooks related to roles and responsibilities in PCMH transformation
Describe the leadership role in PCMH transformation	List leadership responsibilities in transforming a practice to PCMH List leadership responsibilities in transforming a practice to PCMH	http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Feb/Guiding-Transformation.aspx • Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes: Outlines and describes the changes that most medical practices would need to make to become patient-centered medical homes http://www.eiconsortium.org/ • Emotional Intelligence Consortium Website: Describes how emotional intelligence contributes to the bottom line in any work organization www.kotterinternational.com • Leading Change – John Kotter: Helps organizations through transformation, to be independently capable of taking on any obstacle and achieving successful, sustained change http://instituteforbehavioralhealthintegration.org/media/9626/engaged_leadership.pdf • Strategies for Guiding PCMH Transformation from Within: Explains the areas in which leaders can most effectively use their time and energies to drive and sustain transformation

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	Discuss ways you can take on and/or support the leadership role in transforming to PCMH	Recommendation: Develop learning activity by leveraging this resource: http://instituteforbehavioralhealthintegration.org/media/9626/engaged_leadership.pdf • Strategies for Guiding PCMH Transformation from Within: Explains the areas in which leaders can most effectively use their time and energies to drive and sustain transformation
Recognize the importance of leadership, collaboration and effective communication skills in managing change	Given a scenario describing obstacles in a change management initiative, identify best practices for leadership, collaboration and effective communication to improve the situation	Recommendation: Develop scenario and learning activity by leveraging this resource: http://www.leadership-and-motivation-training.com/managing-resistance-to-change.html • Managing Resistance To Change: Discusses how to manage resistance to change
Identify leadership skills necessary for transforming to PCMH	Given a scenario, discuss ways to align system capabilities with organizational needs in PCMH transformation	Recommendation: Develop scenario leveraging this resource: http://www.transformed.com/news-eventsdetailpage.cfm?listingID=136 • TransforMED improves Change Readiness Survey tool for Patient-Centered Medical Home primary care mode: Aims to make it easier and faster to measure a medical practice team's ability to manage and sustain the changes necessary for successful transformation to a PCMH
Define systems thinking	Define systems thinking in the context of change management and PCMH	http://www.hqp.org/blog/?cat=15 Health Quality Partners Blog: Defines systems thinking in PCMH
Apply systems thinking to the PCMH change process	Given a scenario, identify ways to take a systems approach to managing the PCMH transformation	Recommendation: Develop learning activity by leveraging this resource: https://primarycare.hms.harvard.edu/sites/default/files/J%20Amb%20Care%20Mgmt%202012%20Case%20Study_1.pdf • Spreading a Patient-Centered Medical Home Redesign: A Case Study: Describes how an integrated delivery system developed and implemented a PCMH intervention that included standardized structural and practice level changes

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	Discuss specific ways you can take a systems approach to the PCMH transformation in your role	http://www.aafp.org/news-now/practice-professional-issues/20120613pcmhmakeover3.html • Building on Successful Patient-Centered Medical Home Transformation: Provides an example of one family physician's commitment to building a patient-centered medical home practice
Describe the importance of adaptability and flexibility in PCMH transformation	Explain the importance of adaptability and flexibility in PCMH transformation	http://www.transformed.com/news-eventsdetailpage.cfm?listingID=136 • TransforMED improves Change Readiness Survey tool for Patient-Centered Medical Home primary care mode: Aims to make it easier and faster to measure a medical practice team's ability to manage and sustain the changes necessary for successful transformation to a PCMH
Describe best practices for adaptability and flexibility	List ways effective PCMHs adapt to diverse people, populations and systems	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2869425/ • Defining and Measuring the Patient-Centered Medical Home: Discusses that due to adaptability to diverse people, populations and systems, functional PCMHs will look different in different settings
	Identify situations that require adaptability and flexibility when transforming to PCMH	http://thecommonwealthfund.net/~/media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patientcentered_med_home_v2.pdf • Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes: Proposes characteristics of medical homes—called change concepts—which provide general directions for transforming a practice
	Describe specific ways you can adapt and be flexible during the transformation	Recommendation: Develop learning activity by leveraging this resource: http://thecommonwealthfund.net/~/media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patientcentered_med_home_v2.pdf • Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes: Proposes characteristics of medical homes—called change concepts—which provide general directions for transforming a practice

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Patient Self-Management		
Define patient self-management and distinguish it from patient education	Describe the difference between self-management and patient education	http://www.effectivepractice.org/site/ywd_effectivepractice/assets/pdf/4a_Self-Management_-_Discussion_Paper.pdf • Patient Self-Management – A Discussion Paper: Provides basic comparative information on chronic disease self-management and traditional health education as applied to diabetes http://www.nap.edu/openbook.php?record_id=11085&page=57 • Patient Self-Management Support: Defines patient self-management
	Describe a strategy to help patients gain self-efficacy and change their lifestyle behaviors	http://www.improvingchroniccare.org/downloads/selfmanagement_support_toolkit_for_clinicians_2012_update.pdf • Partnering in Self-Management Support: A Toolkit for Clinicians: Introduces a set of activities and changes that support patients and families in the day-to-day management of chronic conditions http://www.cincinnatichildrens.org/assets/0/78/1067/2709/2777/2793/9199/a8b6f19b-e8fe-476e-9ee1-6b51a7112e28.pdf • Evidence-Based Care Guideline to Chronic Care: Self-Management: Provides evidence-based recommendations for self-management by families of children with chronic conditions to improve health outcomes *Living a Healthy Life With Chronic Conditions*; 4th Edition: Self-Management of Heart Disease, Arthritis, Diabetes, Depression, Asthma, Bronchitis, Emphysema & Other Physical & Mental Health Conditions. by Kate Lorig RN DrPH, Halsted Holman MD, David Sobel MD MPH, Diana Laurent MPH, Virginia González MPH, and Marian Minor RPT PhD. Bull Publishing, 2012
Follow the steps for developing patient action plans	Recognize the steps for developing patient action plans	http://www.ddcmultimedia.com/doqit/Care_Management/CM_PSM/L3P6.html • Action Planning: Describes the process of action planning with patients

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		http://www.mipcc.org/sites/mipcc.org/files/u4/Personal%20Action%20Plan.pdf • Patient-Centered Medical Home Toolkit: Shows an example of an action plan
	Explain to patients how to access their personal care plans	http://www.medicalhomeinfo.org/how/care_delivery/ • Care Delivery Management: Provides examples of resources and tools available to enhance the management of care delivery
	Describe the process for aligning the personal care plan and action plan	http://archive.pcpcc.net/content/guided-care • Guided Care: Describes the most current evidence-based guidelines for managing chronic conditions and the most effective principles from case management, disease management, self-management, transitional care, geriatric evaluation, and caregiver support models into primary care http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-16-2011/No2-May-2011/Patient-Centered-Care-in-a-Medical-Home.html • Patient-Centered Care in a Medical Home
Assist patients in developing an action plan for disease prevention and health maintenance	Given a case study, create an action plan for disease prevention and health maintenance	Recommendation: Develop learning activity by leveraging these resources: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HelpingPatientsManageTheirChronicConditions.pdf • Helping Patients Manage their Chronic Conditions: Describes strategies to help promote patient self-management http://www.mipcc.org/sites/mipcc.org/files/u4/Personal%20Action%20Plan.pdf • Patient-Centered Medical Home Toolkit: Shows an example of an action plan
Assist patients and their families in self-care management with information, tools and resources	Identify specific information, tools and resources to assist patients and their families in self-care for a variety of situations	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2587225/ • Implementation of Open Access Scheduling in Primary Care: A Cautionary Tale: Assesses the impact of open access implementation and examines barriers to implementing this model http://www.aap.org/en-us/professional-resources/practice-support/quality-improvement/Pages/Quality-

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		Improvement-Open-Access-Scheduling.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token • Quality Improvement: Open Access Scheduling: Defines and gives the benefits of open access scheduling
Discuss ways to help overcome resistance to patient self-management	Given a case study, identify ways to help the patient overcome resistance to self-management	Recommendation: Develop learning activity by leveraging these resources: http://www.cincinnatichildrens.org/assets/0/78/1067/2709/2777/2793/9199/a8b6f19b-e8fe-476e-9ee1-6b51a7112e28.pdf • Evidence-Based Care Guideline to Chronic Care: Self-Management: Provides evidence-based recommendations for self-management by families of children with chronic conditions to improve health outcomes http://blogs.hbr.org/kanter/2012/09/ten-reasons-people-resist-chang.html • Ten Reasons People Resist Change: Lists predictable, universal sources of resistance to various situations and how to strategize around them http://www.eufic.org/article/en/artid/Motivating-change-Tips-for-health-care-professionals/ • Motivating change: Tips for health care professionals
Care for patients and families with sensitivity to each patient's culture	Design practice, administrative, and organizational accommodations that contribute to a culturally competent/responsive practice setting	http://www.aafp.org/about/policies/all/care-minority.html • Principles for Improving Cultural Proficiency and Care to Minority and Medically-Underserved Communities
	Identify specific behaviors in a practice that contribute to cultural competence	http://www.aafp.org/fpm/2000/1000/p58.html Improving Patient Care: Cultural Competence: Defines cultural competence and how to implement it in patient care
	Recognize your responsibilities that contribute to cultural competence in your practice	Recommendation: Develop learning activity by leveraging this resource: http://www.culturediversity.org/cultcomp.htm • Transcultural Nursing – Cultural Competence

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Assesses patient/family self-management abilities	Discuss ways to assess patient/family self-management abilities	http://www.cincinnatichildrens.org/assets/0/78/1067/2709/2777/2793/9199/a8b6f19b-e8fe-476e-9ee1-6b51a7112e28.pdf • Evidence-Based Care Guideline to Chronic Care: Self-Management: Provides evidence-based recommendations for self-management by families of children with chronic conditions to improve health outcomes
	Given a case study, follow a model for assessing the patient's abilities to self-manage	Recommendation: Develop case study by leveraging this resource: http://www.cincinnatichildrens.org/assets/0/78/1067/2709/2777/2793/9199/a8b6f19b-e8fe-476e-9ee1-6b51a7112e28.pdf • Evidence-Based Care Guideline to Chronic Care: Self-Management: Provides evidence-based recommendations for self-management by families of children with chronic conditions to improve health outcomes
Use effective interpersonal skills when working with patients in self-management	Given a scenario, identify situations that require effective interpersonal skills Given a scenario, identify situations that require effective interpersonal skills	Recommendation: Develop learning activity by leveraging this resource: http://www.pcpcc.net/sites/default/files/media/pep-report.pdf • Transforming Patient Engagement: Health IT in the Patient Centered Medical Home: Provides resources to support all stakeholder efforts in improved patient and family engagement
	Self-assess your interpersonal skills when helping patients in self-management	Recommendation: Develop learning activity by leveraging this resource: http://www.transformed.com/resources/pcmh.cfm • Resources : Patient-Centered Medical Home: Provides a list of resources related to patient self-management
	Identify your areas of strength and opportunities for improving your interpersonal skills	Recommendation: Develop learning activity by leveraging this resource: http://www.pcpcc.net/sites/default/files/media/pep-report.pdf • Transforming Patient Engagement: Health IT in the Patient Centered Medical Home: Provides resources to support all stakeholder efforts in improved patient and family engagement

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Manage communications with community agencies and health departments	Given a case study, identify best practices for communicating with community agencies and health departments	Recommendation: Develop case study and learning activity by leveraging this resource: http://www.partnersinhealth.unc.edu/PiH_Manual.pdf • Community Building: Effective Community Communication – Best Practices
Assess the patient's health literacy to ensure complete understanding	Follow a brief method for assessing patient health literacy	http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html • Health Literacy Measurement Tools
	Discuss ways to work with patients to improve areas of health literacy and ensure they can read and understand educational material provided	http://www.health.gov/communication/literacy/quickguide/ • Quick Guide to Health Literacy
Discuss the role of evidence-based guidelines in patient self-management	Identify ways to use evidence-based guidelines in patient self-management	http://www.safetynetmedicalhome.org/change-concepts/organized-evidence-based-care • Organized, Evidence-Based Care: Provides evidence-based care resources
Recognize the available community resources	Connect with community resources to extend resources for care	http://www.mgma.com/store/Books/PCMH-Policies-and-Procedures-Guidebook/ • PCMH Policies and Procedures Guidebook: Provide Self-Care Support and Community Resources, chapter 4
	Identify resources to assist patients with self-management	http://www.pcdc.org/resources/patient-centered-medical-home/ • Patient-Centered Medical Home: Provides links and resources for self-management
Assist patients in connecting with peer support groups or other appropriate community resources	Identify best practices for connecting patients with peer support groups or other appropriate community resources	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2869421/ • Good Neighbors: How Will the Patient-Centered Medical Home Relate to the Rest of the Health-Care Delivery System?