Topics for students to empanel by week 41 (Cardiopulmonary block):

Students need to identify a patient from their practice with one of the following:
Complaints of:
Palpitations
Chest pain
Shortness of Breath
Wheezing

AND/OR
Cigarette use (or exposure to passive smoke)
Difficulty completing activities of daily living
Obesity affecting their health

Please review the use of the empanelling worksheet and of basic measures to anonymatize patient data with the students for their collection of patients. Remind the students that they will be responsible for presenting their empanelled patient during week 41

The Chronic Care Model and Use of Primary Care Medical Home –these concepts will be introduced during the Cardiopulmonary Block

A more detailed presentation by Dr Donald Mack is available on VITALS and will be added to the website for FD4MeLP—**HERE ARE SOME HIGHLIGHTS**

The Chronic Care Model proposes that there are 6 essential elements to effective chronic disease management. These include:

1. *the community—including services that are not available at the physician office, such as nutrition counseling, and peer-support groups*
2. *the health system—with changes that improve chronic illness care through leadership and incentives*
3. *self-management support—encompassing both individual and group interventions encourage patients to learn effective, self-management skills*
4. *delivery system design—coordinating multiple caregivers to improve clinical outcomes and healthcare utilization*
5. *decision support—integrating evidence-based guidelines into registries, flow sheets, and patient assessment tools to affect physician practice*
6. *clinical information systems—which assist physicians to deliver preventive care, organize treatment teams, and remind patients of recommended care*

The Principles of the PCMH, include:

- *the concept of the personal physician*
- *a physician-directed, team-based approach to medical practice*

- *a whole-person orientation*
- *coordinated and integrated care*
- *quality and safety*
- *enhanced access*
- *an appropriate payment framework*

PCMH is focused on improving chronic illness care, transforming medical care to be more cost effective, and ensuring improved quality and efficacy.

Planned Care Model

- *Evidenced-based, preventive care*
- *Uses registries*
- *Team assists patients to improve self-management*
- *Proactive rather than reactive care*