Chronic Care Model and PCMH model matrix

Chronic Care Model		PCMH Standards and Elements	
Delivery System Design	Define roles and distribute tasks among team members • Use planned interactions to support evidence-based care • Provide clinical case management services for complex patients • Ensure regular follow-up by the care team • Give care that patients understand and that fits with their cultural background	**PCMH 1: Enhance Access and Continuity**	• Element A: Access During Office Hours • Element B: After-Hours Access • Element C: Electronic Access • Element D: Continuity • Element E: Medical Home Responsibilities • Element F: Culturally and Linguistically Appropriate Services (CLAS) • Element G: The Practice Team
Clinical Information Systems	Organize patient and population data to facilitate efficient and effective care • Provide timely reminders for providers and patients • Identify relevant subpopulations for proactive care • Facilitate individual patient care planning • Share information with patients and providers to coordinate care • Monitor performance of practice team and care system	**PCMH 2: Identify and Manage Patient Populations**	• Element A: Patient Information • Element B: Clinical Data • Element C: Comprehensive Health Assessment • Element D: Use Data for Population Management
Decision Support	Promote clinical care that is consistent with scientific evidence and patient preferences • Embed evidence-based guidelines into daily clinical practice • Share evidence-based guidelines and information with patients to encourage their participation • Use proven provider education methods • Integrate specialist expertise and primary care	**PCMH 3: Plan and Manage Care**	• Element A: Implement Evidence-Based Guidelines • Element B: Identify High-Risk Patients • Element C: Care Management • Element D: Medication Management • Element E: Use Electronic Prescribing
Self Management Supports	Empower and prepare patients to manage their health and health care • Emphasize the patient's central role in managing their health • Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up • Organize internal and community resources to provide ongoing self-management support to patients	**PCMH 4: Provide Self-Care Support**	• Element A: Support Self-Care Process • Element B: Provide Referrals to Community Resources
Community Linkages	Mobilize community resources to meet needs of patients • Encourage patients to participate in effective community programs • Form partnerships with community organizations to support and develop interventions that fill gaps in needed services • Advocate for policies to improve patient care		
Organization of Care	Create a culture, organization and mechanisms that promote safe, high quality care • Visibly support improvement at all levels of the organization, beginning with the senior leader • Promote effective improvement strategies aimed at comprehensive system change • Encourage open and systematic handling of errors and quality problems to improve care • Provide incentives based on quality of care • Develop agreements that facilitate care coordination within and across organizations	**PCMH 5: Track and Coordinate Care**	• Element A: Test Tracking and Follow-Up • Element B: Referral Tracking and Follow-Up • Element C: Coordinate With Facilities and Manage Care Transitions
		PCMH 6: Measure and Improve Performance	• Element A: Measure Performance • Element B: Measure Patient/Family Experience • Element C: Implement Continuous Quality Improvement • Element D: Demonstrate Continuous Quality Improvement • Element E: Report Performance • Element F: Report Data Externally • Element G: Use Certified EHR Technology