Patient Centered Medical Home Network

The Patient Centered Medical Home (PCMH) Network is co-chaired by **David Dorr**, MD, MS, Associate Professor and Vice Chair, Medical Informatics and Clinical Epidemiology and **Colleen Casey**, PhD, ANP-BC, CNS, Assistant Professor, Division of General Internal Medicine & Geriatrics, both of Oregon Health & Science University in Portland, OR.

Additionally, the Network has enlisted five geriatrics experts in the field of health care:

- **Molly Mettler**, MSW, Senior Vice President of Mission, Healthwise (Boise, ID)
- **Toni Miles**, MD, PhD, Director, Institute of Gerontology, University of Georgia (Athens, GA)
- **Aanand Naik**, MD, Associate Professor, Houston Center for Innovations in Quality, Effectiveness, and Safety at the Michael E. DeBakey VA Medical Center and Baylor College of Medicine (Houston, TX)
- **Rob Schreiber**, MD, Medical Director of Evidence-based Programs, Hebrew Senior Life, Medical Director of the Healthy Living Center of Excellence, and Clinical Instructor of Medicine, Harvard Medical School (Boston, MA)
- **Tasha Woodall**, PharmD, CGP, CPP, Associate Director of Pharmacotherapy in Geriatrics, Mountain Area Health Education Center (Asheville, NC)

The vision of the Network is to transform PCMHs to recognize, facilitate, encourage, and ultimately improve the care of older adults and their caregivers. We also propose to enhance their connection to relevant resources, including family caregivers and community-based resources. By advocating for and promoting the thoughtful insertion of geriatrics into the PCMH model and the eventual implementation of two to three geriatrics-specific pilot projects in PCMH settings, the Network seeks to improve outcomes for older adults in the Comprehensive Primary Care (CPC) initiative and other PCMH sites. A large thrust of the Network will be to identify ways to improve the skills of PCMH clinicians who may not have formal geriatric training, at both the patient and population level. These efforts may include evidence-based geriatrics education on specific topics, appropriate risk identification and stratification, and more geriatric sensitive care management.

It is the goal of the Network to support better policy and implementation by reframing the PCMH model to establish the value of caring for older adults and defining a set of PCMH models and policy changes that increase the likelihood of better outcomes for older adults. In order to meet these objectives, Network team members will collaborate to distill our ideas into measurable, actionable, and timely goals. The Network will also seek input from other Hartford Foundation initiatives and geriatrics experts in health care.

During the next two years, the Network's members will identify several topics of critical importance to the field of geriatrics in PCMHs and establish and execute a plan of action. This will be accomplished with public input and in coordination with other initiatives of the Hartford Foundation, GSA, and federal and private partners.

For more information about this Network

Please email changeagents365@geron.org or Shelby Martin at martshe@ohsu.edu.

Or visit us at: http://www.changeagents365.org/change-agents-networks/medical-homes

About the Hartford Change AGEnts Initiative

The Hartford Change AGEnts Initiative accelerates sustained practice change that improves the health of older Americans, their families, and communities. It does this by harnessing the collective strengths, resources, and expertise of the John A. Hartford Foundation's interprofessional community of more than 3,000 scholars, clinicians, and health system leaders.

See more at: http://www.changeagents365.org/