MA-2620: PATIENT-CENTERED MEDICAL HOME

Cuyahoga Community College

Viewing: MA-2620 : Patient-Centered Medical Home

Board of Trustees:
2017-05-25

Academic Term:
2017-08-24

Subject Code
MA - Medical Assisting

Course Number:
2620

Title:
Patient-Centered Medical Home

Catalog Description:
Advanced training for students to work with Patient-Centered Medical Homes by coordinating care between the medical team and the patient. Includes concepts, applications, intervention strategies, and implementations for successful patient care.

Credit Hour(s):
2

Lecture Hour(s):
2

Requisites

Prerequisite and Corequisite
Departmental approval: admission to Patient Navigator program.

Outcomes

Course Outcome(s):
Describe and Define the Patient-Centered Medical Home.

Essential Learning Outcome Mapping:
Information Literacy: Acquire, evaluate, and use information from credible sources in order to meet information needs for a specific research purpose.

Objective(s):
1. Define Patient-Centered Medical Home.
2. Compare the Patient-Centered Medical Home with the historical view of healthcare.
3. Distinguish the varies roles and responsibilities within the Patient-Centered Medical Home.

Course Outcome(s):
Create, implement, evaluate and revise a plan of care.

Essential Learning Outcome Mapping:
Critical/Creative Thinking: Analyze, evaluate, and synthesize information in order to consider problems/ideas and transform them in innovative or imaginative ways.
Cultural Sensitivity: Demonstrate sensitivity to the beliefs, views, values, and practices of cultures within and beyond the United States.
Oral Communication: Demonstrate effective verbal and nonverbal communication for an intended audience that is clear, organized, and delivered effectively following the standard conventions of that language.
Written Communication: Demonstrate effective written communication for an intended audience that follows genre/disciplinary conventions that reflect clarity, organization, and editing skills.

Objective(s):

1. Define a plan of care in relation to coordination of care.
2. Describe which patient groups would benefit from a coordination of care.
3. Create a plan of care for a specific chronic illness.
4. Evaluate the outcomes of the plan of care and made revisions to benefit the patient.

Course Outcome(s):

Support and Design changes in health behavior.

Essential Learning Outcome Mapping:

Critical/Creative Thinking: Analyze, evaluate, and synthesize information in order to consider problems/ideas and transform them in innovative or imaginative ways.
Oral Communication: Demonstrate effective verbal and nonverbal communication for an intended audience that is clear, organized, and delivered effectively following the standard conventions of that language.

Objective(s):

1. Present a demonstration and re-demonstration strategy for behavior change.
2. Identify community resources for multiple chronic illnesses that will encourage behavior change.
3. Illustrate the patient navigator role in a chronic illness prevention strategy through behavior change.
4. Design two tolls to encourage behavior change.

Course Outcome(s):

Apply Health Literacy to patient navigation.

Essential Learning Outcome Mapping:

Critical/Creative Thinking: Analyze, evaluate, and synthesize information in order to consider problems/ideas and transform them in innovative or imaginative ways.
Written Communication: Demonstrate effective written communication for an intended audience that follows genre/disciplinary conventions that reflect clarity, organization, and editing skills.

Objective(s):

1. Develop health educational materials written at a 3rd grade, 5th grade and 8th grade level.
2. Create health education materials for a chronic illness.
3. Define social and cultural determinants of health.

Methods of Evaluation:

Exams

Research paper

Educational pamphlets

Case Studies

Role-playing

Course Content Outline:

1. Define Patient-Centered Medical Home
   a. History
   b. Roles and Responsibilities
2. Coordination of Care
   a. Define
   b. Role of a plan of care
   c. Steps to creating, implementing, evaluating and revising a plan of care
3. Health Behavior in the PCMH
   a. Chronic Illness; comorbidities defined
   b. Health Belief model and behavior change theories
   c. Strategies for behavior change
4. Community Resources for Chronic illnesses
   a. Development of pamphlets
   b. Design a support group
5. Health Literacy and the PCMH

a. Literacy levels in health education materials
b. Social and cultural determinants of health and health literacy

Resources

Christopher W. Eldridge. (2013-05-31 22:00:00.0) Expanding Roles of Medical Assistants in the Patient Centered Medical Home. Paper 19.

Robert A. Berenson, Suzanne F. Delbanco, Roslyn Murray, Divvy K. Upadhyay. (2016-03-31 22:00:00.0) The Patient Centered Medical Home--Advanced Primary Care.

Karin V. Rhodes, MD, MS, Simon Basseyn, BA, Robert Gallop, PHD, Elizabeth Noll, PhD, Aileen Rothbard, SCD, and Paul Crits-Christoph, PhD. (2016-04-28 22:00:00.0) Pennsylvania's Medical Home Initiative: Reductions in Healthcare Utilization and Cost Among Medicaid Patients with Medical and Psychiatric Comorbidities. 31(11).

Lipson D, Rich E, Libersky J, Parchman M. (2011-09-30 22:00:00.0) Ensuring That Patient-Centered Medical Homes Effectively Serve Patients with Complex Health Needs. ARHQ No. 11-0109.

Nadine Reibling. (2015-10-21 22:00:00.0) The Patient-Centered Medical Home: How Is It Related to Quality and Equity Among the General Adult Population?. 73(5).

Top of page
Key: 2758