

The Geriatrics Patient Centered Medical Home
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The Challenge: The Coffey Geriatrics Practice at the Mount Sinai Medical Center serves more than 2,500 community-dwelling older adults. The average age of patients is 85 years, one-third are Medicaid eligible, and 30% identify themselves as Hispanic and 25% as African-American. Care is currently delivered with a traditional primary care model. Under this fragmented system, staff and physicians express burnout and frustration with the daily demands of patient care. Patients feel overwhelmed by the healthcare system. The purpose of this project is to pilot a model of care for older adults that will improve patient and provider satisfaction while enhancing care quality.

The Proposal: The proposed new model of care will be based on the Patient Centered Medical Home (PCMH) described by the American College of Physicians (ACP) and reflects the input of multiple primary care organizations. The PCMH has gained national attention as a model that could improve the quality and outcomes of care. With an emphasis on teams, access, continuity, patient self-management, disease management, and coordination, the PCMH can be adapted for geriatric populations. This model provides an opportunity to change care delivery to optimize the contributions of every team member by enhancing efficiency, patient care, and job satisfaction.

The Process and Outcomes: Specific changes to current practice will reflect the National Committee for Quality Assurance (NCQA) criteria developed in conjunction with the ACP to assess whether practices are functioning as medical homes. The criteria consist of nine standards, such as use of electronic communications, care management that implements evidence-based guidelines, and support for patient self-management. Evidence-based guidelines will be geriatric specific and include management plans with attention to conditions such as memory loss, incontinence and falls. Current interdisciplinary team members at the Coffey Geriatrics Practice will integrate the NCQA standards into daily practice through systems changes and practice improvement initiatives. Patients and caregivers will also be educated on how they are part of the PCMH and advised of their own responsibilities in maintaining health and function. Measured outcomes will include patient and staff satisfaction, quality of care and cost of care.

Please [email Audrey](#) with any questions or comments regarding this project.