Welcome

Patient-Centered Medical Home: a case study on achieving Level 3

August 10, 2011

We will begin promptly @ 2PM EDT

Event Host

Melissa DaSilva
Deputy Director
National Health Care for the Homeless Council

This presentation is supported through a National Cooperative Agreement with the Health Resources and Services Administration.
M.C. and Presenter

Anna Gard, FNP-BC
• Health Disparities Consultant for ACU
• HIT workforce development committee member of National Health IT Collaborative for the Underserved
• Special populations clinical consultant

Katherine Brieger, RD, CDE
• Chief Operating Officer, Hudson River HealthCare
• President, Association of Clinicians for the Underserved
Overview of Today’s Presentation

- Brief introduction to Medical Home
- Overview of PCMH Level 3 recognition process
- Q & A
Building Patient Centered Medical Homes with Transdisciplinary Teams

August 10, 2011

Katherine Brieger, RD, CDE
Chief Operating Officer Hudson River HealthCare
President Association of Clinicians for the Underserved
Medical Homes: 2008

- Old idea: American Academy of Pediatrics 1960s
- Patient Centered Primary Care Collaborative (2006)
  - Employers (IBM)
  - Payers (Wellpoint, Aetna, many others)
  - Primary Care Academies
  - Consumer groups
The Medical Home

• A medical home is not simply a place but a model of primary care that delivers care that is:
  – Patient-Centered
  – Comprehensive
  – Coordinated
  – Accessible, and
  – Continuously improved through a systems-based approach to quality and safety
Patient-Centered Medical Home – The Benefits

Cost (efficiency)
“Bend the trend”
Increase affordability
Preventable, duplicative and unnecessary care

Satisfaction
Patient Experience and Access (CG-CAPHS)
Physician Experience
Care Team

Quality (effectiveness)
Population Health Care
Communication
Care Coordination

Reimbursement
Incentives from key payors,
including NY Medicaid

<table>
<thead>
<tr>
<th>Organization</th>
<th>Better Quality</th>
<th>Better Work Environment</th>
<th>Reduction in ER &amp; Inpatient Hospital Costs</th>
<th>Better Patient Satisfaction &amp; Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Health Cooperative</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Community Care of North Carolina</td>
<td>X</td>
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<td></td>
<td></td>
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<td>HealthPartners Medical Group</td>
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<td>X</td>
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<tr>
<td>Geisinger Health System</td>
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<td></td>
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<tr>
<td>Genesee Health Plan</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Colorado Medicaid &amp; SCHIP</td>
<td>X</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>Intermountain Healthcare</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Johns Hopkins</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure ES-4. Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes

Percent of adults 18–64 reporting always getting care they need when they need it

- Medical home
- Regular source of care, not a medical home
- No regular source of care/ER

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>White</th>
<th>African American</th>
<th>Hispanic</th>
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</thead>
<tbody>
<tr>
<td>Medical home</td>
<td>74</td>
<td>74</td>
<td>76</td>
<td>74</td>
</tr>
<tr>
<td>Regular source of care, not a medical home</td>
<td>52</td>
<td>53</td>
<td>52</td>
<td>50</td>
</tr>
<tr>
<td>No regular source of care/ER</td>
<td>38</td>
<td>44</td>
<td>31</td>
<td>34</td>
</tr>
</tbody>
</table>

Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.

Source: Commonwealth Fund 2006 Health Care Quality Survey.
Commonwealth Fund Initiative

• Transforming Safety Net Clinics into Patient-Centered Medical Homes
  – Awarded to Qualis Health of Seattle
  – Partnered with MacColl Institute (Dr. Ed Wagner)
  – Over 60 safety net providers in 4 regions achieve advanced medical home status-great resources
Beyond the Medical Home

• Addressing the deeper roots of disparities
  – Economic Security
  – Educational and Career Opportunities
  – Addressing Racism and Building Trust
• Linkages to educational and economic community institutions
• Assistance in accessing economic benefits
• Building a diverse healthcare workforce and delivering care in a team-based setting
• Whole person care
Beyond the Medical Home: A Health Care Home

- Integration of medical, oral, and behavioral health
- Pharmacy and lab services
- Facilitated enrollment into public benefit programs
- On site WIC services
- Outreach and transportation
- Community involvement and linkages
Special Considerations for Clinicians Caring for people without homes....

- Some of the methods used to fulfill the PCMH requirements need to be modified.
- Self Management and Patient Involvement will need to be modified.
- Working with partners will be even more critical to achieve certification for PCMH.
2011 NCQA PCMH Standards

- Enhance Access and Continuity
  - Empanelment work
  - Open weekend and evening care centers
- Identify and Manage Patient Populations
- Plan and Manage Care
2011 NCQA PCMH Standards

- Provide Self Care Support and Community Resources
  - Continued training on EHR documentation

- Track and Coordinate Care
  - Improve Care Coordination
    - Develop Nurse Care Manager for sickest patients
    - Standardize tracking workflow using teams
  - Improve e-prescribing rates
  - Achieve Meaningful Use by 2Q 2012

- Measure and Improve Performance
  - Refine CAHPS usage
How much will this cost?

Keeping on track as changes occur in payments

Its a Journey
Who is on your team?

- Patient and maybe the caregiver
- Medical Providers
- Nursing: LPN, RN, Care managers
- Clinical Assistants
- Patient Care Partner
- Dentists, Dental Hygienists
- Patient Representatives
- Clinical support: Laboratory Staff, Nutritionist, Social Worker, Podiatry, Optometry
- Outreach, Community Care Partners, Americorp
Tips for Developing Your Team

• Have a **core team** and bring in others as needed
• Time required can vary across team
  – Project lead: up to **10 hrs / week**
  – Other team members: approx. **4-6 hrs / week**
• If network is looking to get multiple locations recognized, need **knowledge of on-the-ground operations for ALL locations included**
- All clinical assessment, evaluation, treatment and care is managed through the partnership between provider and patient.

- Vitals
- Smoking and PHQ assessment
- Referrals to HRHCare classes

- Self-management questions
- Goal assessment
- Review and management of treatment plan
- Use of registries for planned care visits

- Use of interface between EHR and health center staff.

- Evaluation, assessment and counseling of patients
- Self-management

- Medication management
- Review of referrals
- Instruction on self-management

- Assistance with translation, transportation, appointments with referrals; PAP; diagnostic tests
- Dietitian referrals

- Assessment, evaluation, and nutrition counseling.
- Self-management support for patients
Transdisciplinary Team

• All members of the team are needed in delivering care
• Front line staff are often the ones who are trusted and will help patients access care
• Working with team members who are experienced in working with people who have challenges, will improve health outcomes
Using External Partners

- Homeless Shelters
- Street Outreach Workers
- Regional Health Information Networks
- CHC/FQHC/Free Clinics
- Mental Health Association
- Other Health Centers
- Hospitals
- Meal Programs/Distribution centers
Detailed PCMH Assessment
# PPC-PCMH Content and Scoring

<table>
<thead>
<tr>
<th>Standard 1: Access and Communication</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Has written standards for patient access and patient communication**</td>
<td>4</td>
</tr>
<tr>
<td>B. Uses data to show it meets its standards for patient access and communication**</td>
<td>5</td>
</tr>
<tr>
<td>C. Uses data to show it meets its standards for patient communication</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 2: Patient Tracking and Registry Functions</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Uses data system for basic patient information (mostly non-clinical data)</td>
<td>2</td>
</tr>
<tr>
<td>B. Has clinical data system with clinical data in searchable data fields</td>
<td>3</td>
</tr>
<tr>
<td>C. Uses the clinical data system</td>
<td>3</td>
</tr>
<tr>
<td>D. Uses paper or electronic-based charting tools to organize clinical information**</td>
<td>6</td>
</tr>
<tr>
<td>E. Uses data to identify important diagnoses and conditions in practice**</td>
<td>4</td>
</tr>
<tr>
<td>F. Generates lists of patients and reminds patients and clinicians of services needed (population management)</td>
<td>21</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 3: Care Management</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Adopts and implements evidence-based guidelines for three conditions **</td>
<td>3</td>
</tr>
<tr>
<td>B. Generates reminders about preventive services for clinicians</td>
<td>4</td>
</tr>
<tr>
<td>C. Uses non-physician staff to manage patient care</td>
<td>3</td>
</tr>
<tr>
<td>D. Conducts care management, including care plans, assessing progress, addressing barriers</td>
<td>5</td>
</tr>
<tr>
<td>E. Coordinates care/follow-up for patients who receive care in inpatient and outpatient facilities</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
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</tbody>
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<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>A. Assesses language preference and other communication barriers</td>
<td>2</td>
</tr>
<tr>
<td>B. Actively supports patient self-management**</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 5: Electronic Prescribing</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Uses electronic system to write prescriptions</td>
<td>3</td>
</tr>
<tr>
<td>B. Has electronic prescription writer with safety checks</td>
<td>3</td>
</tr>
<tr>
<td>C. Has electronic prescription writer with cost checks</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 6: Test Tracking</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Tracks tests and identifies abnormal results systematically**</td>
<td>7</td>
</tr>
<tr>
<td>B. Uses electronic systems to order and retrieve tests and flag duplicate tests</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 7: Referral Tracking</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Tracks referrals using paper-based or electronic system**</td>
<td>4</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 8: Performance Reporting and Improvement</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Measures clinical and/or service performance by physician or across the practice**</td>
<td>3</td>
</tr>
<tr>
<td>B. Survey of patients’ care experience</td>
<td>3</td>
</tr>
<tr>
<td>C. Reports performance across the practice or by physician **</td>
<td>3</td>
</tr>
<tr>
<td>D. Sets goals and takes action to improve performance</td>
<td>3</td>
</tr>
<tr>
<td>E. Produces reports using standardized measures</td>
<td>2</td>
</tr>
<tr>
<td>F. Transmits reports with standardized measures electronically to external entities</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 9: Advanced Electronic Communications</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Availability of Interactive Website</td>
<td>1</td>
</tr>
<tr>
<td>B. Electronic Patient Identification</td>
<td>2</td>
</tr>
<tr>
<td>C. Electronic Care Management Support</td>
<td>1</td>
</tr>
<tr>
<td>D. Electronic Referral Management Support</td>
<td>4</td>
</tr>
</tbody>
</table>

**Must Pass Elements**
### NCQA Scoring Methodology

<table>
<thead>
<tr>
<th>Level</th>
<th>Points</th>
<th>Must-Pass Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>25-49</td>
<td>5 of 10, with a performance level of at least 50%</td>
</tr>
<tr>
<td>Level 2</td>
<td>50-74</td>
<td>10 of 10, with a performance level of at least 50%</td>
</tr>
<tr>
<td>Level 3</td>
<td>75-100</td>
<td>10 of 10, with a performance level of at least 50%</td>
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</tbody>
</table>
Navigating the Detailed PCMH Assessment Tool

• Contains 12 tabs
  – One for instructions
  – Two for summary statistics (overall and must pass)
  – One for each of the 9 NCQA PPC-PCMH standards (color-coded)

• Summary statistics automatically calculated
  – Total points
  – # of “must-pass” elements pass at the 50% level
  – Level of recognition (1, 2 or 3)
4-tiered rating system (Columns C – F)

Existing Documentation (Column G)

Documentation and Implementation Next Steps (Columns H & I)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Score Rating</th>
<th>Existing Documentation</th>
<th>Documentation Next Steps (completed for “A”/”B” rated items)</th>
<th>Implementation/Improvement Steps (completed for “C”/”D” rated items)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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<td>6.</td>
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<td>8.</td>
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<td>10.</td>
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<td>11.</td>
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<tr>
<td>12.</td>
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</tbody>
</table>

Total Possible Points for PPC 1: Element A:

4 4 4 4

Total # of Factors with "Yes" for PPC 1: Element A:

0 0 0 0

% Points Received for PPC 1: Element A:

0% 0% 0% 0%

Total # of Points Received for PPC 1: Element A:

0 0 0 0

Must Pass Element - Passed at 50% Level?

NO NO NO NO

Additional Notes for 1A:
Using the PCMH Assessment Tool

<table>
<thead>
<tr>
<th>Effort Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A: Minimal</strong>  (Column C)</td>
<td>Factor is present and practice is likely to receive points with documentation as-is (e.g., policy already documented and implemented)</td>
</tr>
<tr>
<td><strong>B: Low</strong>  (Column D)</td>
<td>Factor is present, but the practice must improve documentation to receive points (e.g., process in place but needs to be documented, data currently captured but report needs to be generated)</td>
</tr>
<tr>
<td><strong>C: Moderate</strong>  (Column E)</td>
<td>Factor and/or documentation requires moderate redesign to receive points (e.g., have parts of process in place but not fully implemented across practice, report is more time-consuming to design and generate)</td>
</tr>
<tr>
<td><strong>D: Significant</strong>  (Column F)</td>
<td>Factor not present and practice must conduct significant redesign to receive points (e.g., requires new or substantial modification of existing electronic systems such as the EMR, requires new protocol, requires discussion and agreement with staff)</td>
</tr>
<tr>
<td>Column</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Column G</td>
<td>• Indicate existing documentation available to show evidence that a given factor is in place at your organization</td>
</tr>
<tr>
<td>Column H</td>
<td>• Indicate next steps to compile/develop documentation (not currently available) to meet NCQA's requirements</td>
</tr>
<tr>
<td>Column I</td>
<td>• Indicate implementation next steps to meet NCQA's requirements; this column will typically be filled out for factors rated with an effort level of C or D</td>
</tr>
</tbody>
</table>
## PCMH Detailed Assessment: Example 1

### PPC 1: ACCESS & COMMUNICATION

<table>
<thead>
<tr>
<th>Factor</th>
<th>Score Rating</th>
<th>Existing Documentation</th>
<th>Documentation Next Steps (completed for &quot;A&quot;/&quot;B&quot; rated items)</th>
<th>Implementation/Improvement Steps (completed for &quot;C&quot;/&quot;D&quot; rated items)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td></td>
</tr>
</tbody>
</table>

**ELEMENT A: ACCESS & COMMUNICATION PROCESSES (MUST PASS)**

The practice establishes in writing standards for the following processes to support patient access:

1. Scheduling each patient with a personal clinician for continuity of care
   - Score: 1
   - Policy: X
   - Documentation Next Steps: Revise policy
     - should clearly state that patients are assigned PCPs and should be scheduled with their PCP for continuity.

2. Coordinating visits with multiple clinicians and/or diagnostic tests during one trip
   - Score: 0
   - Documentation Next Steps: Develop policy and related workflow; train staff to ensure consistency across practice.

3. Determining through triage how soon a patient needs to be seen
   - Score: 1
   - Policy: Y

### Total Possible Points for PPC 1: Element A:

<table>
<thead>
<tr>
<th></th>
<th>4</th>
<th>4</th>
<th>4</th>
<th>4</th>
</tr>
</thead>
</table>

### Must Pass Element - Passed at 50% Level?

|        | NO | YES | YES | YES |

### Additional Notes for 1A:

- [Notes for 1A]
# PCMH Detailed Assessment: Example 1

## PPC 1: ACCESS & COMMUNICATION

### Element A: ACCESS & COMMUNICATION PROCESSES (MUST PASS)

The practice establishes in writing standards for the following processes to support patient access:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Score Rating</th>
<th>Existing Documentation</th>
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<th>Implementation/Improvement Steps (completed for &quot;C&quot;/&quot;D&quot; rated items)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Scheduling each patient with a personal clinician for continuity of care</td>
<td>1</td>
<td>Policy X</td>
<td>Revise policy should clearly state that patients are assigned PCPs and should be scheduled with their PCP for continuity.</td>
<td></td>
</tr>
<tr>
<td>2. Coordinating visits with multiple clinicians and/or diagnostic tests during one trip</td>
<td>0</td>
<td>Document protocol</td>
<td>Develop policy and related workflow; train staff to ensure consistency across practice</td>
<td></td>
</tr>
<tr>
<td>3. Determining through triage how soon a patient needs to be seen</td>
<td>1</td>
<td>Policy Y</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Total Possible Points for PPC 1: Element A:

| 4 | 4 | 4 | 4 |

### Total # of Factors with "Yes" for PPC 1: Element A:

| 2 | 11 | 11 | 11 |

### % Points Received for PPC 1: Element A:

| 25% | 100% | 100% | 100% |

### Total # of Points Received for PPC 1: Element A:

| 1  | 4  | 4  | 4  |

### Must Pass Element - Passed at 50% Level?

| NO  | YES | YES | YES |
Example 1 – Element 1A (Access & Communication Processes)

- Practice establishes in writing standards for
  - **1A1**: scheduling each patient with a personal clinician for continuity of care
    - Practice Response: We schedule patients and have a policy but it doesn’t specifically state our process
  - **1A2**: coordinating visits w/ multiple clinicians and/or dx tests during 1 trip
    - Practice Response: We don’t do this
  - **1A3**: determining through triage how soon a pt needs to be seen
    - Practice Response: We do this and have our process fully documented in Policy Y
## PCMH Detailed Assessment: Example 1

### PPC 1: ACCESS & COMMUNICATION

<table>
<thead>
<tr>
<th>Factor</th>
<th>Score Rating</th>
<th>Existing Documentation</th>
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<th>Implementation/Improvement Steps (completed for &quot;C&quot;/&quot;D&quot; rated items)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>ELEMENT A: ACCESS &amp; COMMUNICATION PROCESSES (MUST PASS) The practice establishes in writing standards for the following processes to support patient access:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Scheduling each patient with a personal clinician for continuity of care
   - Score: 1
   - Policy X
   - Revise policy: should clearly state that patients are assigned PCPs and should be scheduled with their PCP for the continuity.

2. Coordinating visits with multiple clinicians and/or diagnostic tests during one trip
   - Score: 0
   - Document protocol
   - Develop policy and related workflow; train staff to ensure consistency across practice.

3. Determining through triage how soon a patient needs to be seen
   - Score: 1
   - Policy Y

### Total Possible Points for PPC 1: Element A:

| 4 | 4 | 4 | 4 |

### Total # of Factors with "Yes" for PPC 1: Element A:

| 2 | 11 | 11 | 11 |

### % Points Received for PPC 1: Element A:

| 25% | 100% | 100% | 100% |

### Total # of Points Received for PPC 1: Element A:

| 1 | 4 | 4 | 4 |

### Must Pass Element - Passed at 50% Level?

| NO | YES | YES | YES |
Example 2 – Element 6A  
(Test Tracking and Follow-Up)

- **6A1 & 2**: tracks all lab and imaging tests, until results are available, flagging overdue results
  - Practice Response: While this functionality is available in our EMR, we have not implemented nor trained staff on it
- **6A3**: flags abnormal test results, bringing them to a clinician’s attentions
  - Practice Response: Our EMR does this automatically
# PCMH Detailed Assessment: Example 2

## PPC 6: Test Tracking

<table>
<thead>
<tr>
<th>Factor</th>
<th>Score Rating</th>
<th>Existing Documentation</th>
<th>Next Steps</th>
<th>Implementation/Improvement Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>ELEMENT A: TEST TRACKING AND FOLLOW UP (MUST PASS)</td>
<td></td>
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</tr>
<tr>
<td>The practice systematically tracks tests and follows up in the following manner:</td>
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<tr>
<td>1. Tracks all laboratory tests ordered or done within the practice, until results are available to the clinician, flagging overdue results</td>
<td>1</td>
<td>Produce screen shot of list of labs ordered with status for real patient (de-identified)</td>
<td>Implement lab tracking and reporting functionality; train staff on new functionality; create policy and workflow for handling overdue results.</td>
<td></td>
</tr>
<tr>
<td>2. Tracks all imaging tests ordered or done within the practice, until results are available to the clinician, flagging overdue results</td>
<td>1</td>
<td>Produce screen shot of list of images ordered with status for real patient (de-identified)</td>
<td>Implement imaging test tracking functionality; train staff on new functionality; create policy and workflow for handling overdue results.</td>
<td></td>
</tr>
</tbody>
</table>
PCMH Detailed Assessment: Example 2

### PPC 6: Test Tracking

<table>
<thead>
<tr>
<th>Factor</th>
<th>Score Rating</th>
<th>Existing Documentation</th>
<th>Documentation Next Steps (completed for “A”/”B” rated items)</th>
<th>Implementation/Improvement Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
</tbody>
</table>

**ELEMENT A: TEST TRACKING AND FOLLOW UP (MUST PASS)**

*The practice systematically tracks tests and follows up in the following manner:*

1. Tracks all laboratory tests ordered or done within the practice, until results are available to the clinician, flagging overdue results

   - **Score Rating:** 1
   - **Existing Documentation:**
   - **Documentation Next Steps:** Produce screen shot of list of labs ordered with status for real patient (de-identified)
   - **Implementation/Improvement Steps:** Implement lab tracking and reporting functionality; train staff on new functionality; create policy and workflow for handling overdue results.

2. Tracks all imaging tests ordered or done within the practice, until results are available to the clinician, flagging overdue results

   - **Score Rating:** 1
   - **Existing Documentation:**
   - **Documentation Next Steps:** Produce screen shot of list of images ordered with status for real patient (de-identified)
   - **Implementation/Improvement Steps:** Implement imaging test tracking functionality; train staff on new functionality; create policy and workflow for handling overdue results.

3. Flags abnormal test results, bringing them to a clinician’s attention

   - **Score Rating:** 1
   - **Existing Documentation:**
   - **Documentation Next Steps:** Produce screen shot for real patient (de-identified)
   - **Implementation/Improvement Steps:** Refer to example on SharePoint
Referrals and Transitions

• Very difficult to track
• May need to be sure that patient has a card to identify you as the PCP
• Wallet bags which hang on the neck- may be helpful (HCH)
• Tracking is essential for the PCMH
• Systems need to be in place for reports to be returned
IOM standards in terms of referrals

- Timely
- Safe
- Effective
- Patient-Centered
- Efficient
- Equitable
Successful Referrals and transitions include:

• Assuming accountability
• Providing Patient Support
• Building relationships and agreements among providers that lead to shared expectations for communication and care
• Developing connectivity via electronic or other information pathways that encourage timely and effective information flow between providers (including community agencies)
Special Considerations: Health Literacy

• Evaluate all materials that are handed to patients for appropriate literacy level
• Help patients understand how they are to get the medications/treatments they need in simple language
• Be sure to review information that you are giving patients for any confusing or conflicting advice. Help them to understand how to care for themselves in their current situation.
Patient 5: Partnership

**Presentation:** 48 y.o. Hispanic male, Homeless; Type 2 DM (w/insulin); ESRD; significant visual disturbances; BS-600+; dependent on Hot Meal Program

- On Dialysis but has trouble with transportation
- No documentation
- Living in the shelter created many issues with self management
- No medication or money to purchase this
- No family support
Dissemination

Welcome to PCMH Resource Center

The Agency for Healthcare Research and Quality recognizes that revitalizing the Nation’s primary care system is foundational to achieving high-quality, accessible, efficient health care for all Americans. The primary care medical home, also referred to as the patient centered medical home (PCMH), advanced primary care, and the healthcare home, is a promising model for transforming the organization and delivery of primary care.

This Web site provides policymakers and researchers with access to evidence-based resources about the medical home and its potential to transform primary care and improve the quality, safety, efficiency, and effectiveness of U.S. health care.

What is Medical Home?

A medical home is not simply a place but a model of primary care that delivers care that is:

- Patient-centered
- Comprehensive
- Coordinated
- Accessible
- Continuously improved through a systems-based approach to quality and safety

AHRQ believes that Health IT, workforce development, and payment reform are critical to achieving the potential of the medical home. Learn more about AHRQ’s approach to the medical home [here](#).
Patient Centered Medical Home Video
Right Click and Choose “Open Hyperlink” to View
NHCHC PCMH Resources

• Patient-Centered Medical Home Resource Catalog:

• Nine Steps to NCQA Recognition:
  http://www.nhchc.org/Publications/9_Key_steps_to_NCQA_PCMH_Recognition.pdf

• Archived Webinars:
  - PCMH and HCH: an introduction:
    http://www.nhchc.org/Webinars/PCMH.mp4
  - Steps to NCQA Recognition:
    http://www.nhchc.org/Webinars/NCQAPCMHfinal.mp4
Questions
More Information

The National Health Care for the Homeless Council is a membership organization for those who work to improve the health of homeless people and who seek housing, health care, and adequate incomes for everyone. Our site:  www.nhchc.org

• NHCHC offers
  - free individual memberships at:  
    http://www.nhchc.org/council.html#membership
  - organizational memberships which support our policy and advocacy work at:  
    http://www.nhchc.org/councilmembershipform.html
  - no-cost training and technical assistance to HCH grantees, request at:  
    http://www.nhchc.org/TArequest.html

• Detroit Regional Training, free training event, September 19 & 20, 2011 register:  http://www.nhchc.org

• Upcoming webinars:
  - Motivational Interviewing: Wednesday, August 17, 2011, 2PM EDT
  - HCH & Community Mental Health Provider Partnerships: September 22, 2011, 12:30 PM EDT
Thank you for your participation.

Upon exiting you will be prompted to complete a short online survey. Please take a minute to complete the survey to evaluate this webinar production.