Among the plethora of definitions, formulations, and specifications regarding the medical home, there is nearly universal agreement that coordinating the delivery of care and the flow of information needed to support patients and providers in a complex health system is a critical function of a medical home. This issue of the Medical Home Digest explores the notion of care coordination—a key element of the Safety Net Medical Home Initiative’s Change Concepts for Practice Transformation.

A recent survey of small and medium-size physician practices in the United States found low adoption of several key infrastructure supports required to sustain care coordination. For instance, fewer than 10% of small practices use chronic disease registries, and only 3.2% of primary care practices with fewer than 20 physicians use nurse care managers to support patients with chronic conditions.
Although safety net practices frequently face significant challenges related to resources and infrastructure, a number of creative approaches to care coordination are emerging from the SNMHI and other safety net sites.

The key elements of care coordination are described below in an article by Ed Wagner, MD, MPH. Two additional articles describe examples of how these concepts have been translated into practice in SNMHI participating sites in Lane County, Oregon and Denver, Colorado. Other features of this edition include a brief synopsis of evidence supporting the value of care coordination, a review of the NCQA 2011 PCMH recognition standards, and a description of a unique approach to care coordination in the Oklahoma prison system. Finally, the third installment of a series on using electronic health record tools to support the medical home focuses on using EHRs to enhance care management.

Readers interested in additional tools, resources, and information regarding care coordination in medical homes can review the SNMHI’s recently published Care Coordination implementation guide.


Transforming Safety Net Clinics into Patient-Centered Medical Homes

Care Coordination

An ill patient is referred to a specialist, but no consultation note comes back. A patient’s spouse calls to say that the patient was readmitted to the hospital, but the practice never knew about the original hospitalization. A patient is urged to quit smoking, but isn’t sure where to go for help in the community. These problems associated with referrals and care transitions are all too common in primary care practice, and can be frustrating and irritating to patients and their family, as well as to providers. They can also be dangerous if patients fail to get necessary services in a timely way. The prevention of mishaps associated with fragmented care requires active coordination of care, which has been defined as “the deliberate organization of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services”. Coordination also involves assuring that patients and their family caregivers have the information and support that they need to deal with multiple providers and hand-offs. The most effective care coordination appears to be associated with interactive communication among those caring for a patient. The operative word is “deliberate”; seamless care coordination doesn’t often happen without effort in current delivery system.

The following key changes have enabled primary care organizations to improve referrals, transitions, and enhance capacity for their patients:

- Link patients with community resources to facilitate referrals.
- Integrate behavioral health and specialty care into care delivery through co-location or referral agreements.
- Track and support patients when they obtain services outside the practice.
- Follow up with patients within a few days of an emergency room visit or hospital discharge.
• Communicate test results and care plans to patients and authorized care givers.

• Provide care management services for high-risk patients.

To coordinate care effectively, the PCMH must first assume accountability for improving the experience and quality of care when its patients receive care outside the practice. As discussed further in the Care Coordination Implementation Guide and Toolkit, this process begins with identifying key external providers and community resources, and developing relationships and agreements with them. It includes building a practice infrastructure that can: track referrals and transitions, help patients make appointments and connect with relevant providers, and assure timely and effective sharing of useful patient information and care plans between providers and with patients. In addition, an effective PCMH needs to find ways to obtain reliable and timely information about external services not initiated by the practice such as emergency department, hospital, or other provider-initiated care to help assure that patients have safe and effective transitions.

Care coordination pertains to all patients in a practice that need services from a medical or behavioral specialist, community agency, hospital, emergency room, etc., and much of the work can be done effectively by clerical staff. It is often confused with care management, which describes intensive clinical and support services (including care coordination) provided by a nurse or other clinically trained provider to the sickest subset of patients in a practice. Care management is an essential function of a PCMH, and will be discussed more thoroughly with the Organized, Evidence-based Care implementation guide.


In the News

What Makes Care Coordination and Care Management Successful? Guidance from the Literature

Care coordination is gaining acceptance as an effective strategy for improving the quality of care while lowering healthcare costs. Growing evidence also exists regarding the types of care coordination interventions that result in better outcomes, particularly in primary care settings.

Care coordination addresses the medical, social, behavioral, developmental, and related needs of patients and family members. Care coordination also facilitates and standardizes information transfer between facilities. The primary goal of care coordination is providing information, education, linkages, and support to patients and family members so that they receive the right services at the right time. These activities should be performed within the context of a patient-centered care plan, thus promoting alignment with the primary care practitioner as well as the other involved specialty service providers.

Care Coordination includes:

- Linking patients with community resources to facilitate referrals and respond to social service needs.
- Providing care management services for high risk patients.
- Integrating behavioral health and specialty care into care delivery through co-location or referral protocols.
- Tracking and supporting patients when they obtain services outside the practice.
- Following-up with patients within a few days of an emergency room visit or hospital discharge.
- Communicating test results and care plans to patients/families.

Providing care management services for a high-risk population is part of the Care Coordination change concept. Care management improves clinical, financial, and satisfaction outcomes if completed with the right interventions and components. This is demonstrated by a 2009 study\(^1\) that identified three types of interventions that were shown to be effective in reducing hospitalizations for Medicare beneficiaries with multiple chronic conditions:

- **Transitional care interventions:** There are two prominent models for care transitions that have demonstrated the ability to reduce readmissions to hospitals through structured interventions with patients and caregivers as the transition occurs from hospital to home care. Although there are differences in the specific approaches, both models focus on reinforcing the discharge instructions for medications and self-care, understanding symptoms that indicate potential complications that require medical attention, and making follow up appointments with primary care and specialty care.

- **Self-management education interventions:** These are educational programs focused on empowering patients to manage their own health. Interventions are provided by a mix of medical and non-medical professionals and include group activities. The services focus on symptom management, communication skills, medication use, lifestyle management (e.g., diet, exercise, and nutrition), and problem-solving skills.

- **Coordinated care interventions:** This includes a mix of interventions aimed at identifying patients at high risk for health service utilization, conducting initial assessments, patient-centered care planning, and ongoing monitoring of patients.
Current literature indicates that there are six key distinguishing components for successful care management programs. These include:

- **Targeting:** The care manager should have methods for identifying patients at risk for hospitalizations. This includes accessing information about patients who are at risk for high healthcare costs, thus allowing the care manager to conduct outreach to improve those patients’ adherence and communication.

- **In-person contact:** The care manager is most effective where there is a significant amount of in-person contact with enrolled patients. There are other methods of interacting with patients that can be done between in-person visits, including telephone calls, texting, and e-mails. However, evidence exists that regular in-person contact results in better outcomes.

- **Access to timely information on hospital and emergency room admissions:** Care managers are most effective if they learn about an acute care admission shortly after it occurs. This allows the care managers to provide immediate interventions, such as care transition interventions, that are intended to prevent readmissions.

- **Close interactions between care managers and primary care practitioners:** Care management is optimized when services are provided in collaboration with the primary care practitioner. An integrated patient-centered care plan should exist, which allows the care manager to offer support with services that meet the goals of the plan. Most practices have the same care manager working with all program patients for a given primary care practitioner.

- **Services provided:** Care management interventions focus on medical issues, especially the proper use of medications. There is also a need for care management services to address social support needs such as transportation. In addition, care managers can assist with tracking referrals, making appointments, and supporting access to services outside the practice.

- **Staffing:** Care management interventions should involve a mix of registered nurses, social workers, and non-clinical staff members. This allows for the delivery of a range of care management activities in conjunction with the primary care practitioner. It is also critical that staff obtain necessary training on how to properly perform all of the required care management services.

These interventions and components have been identified from a range of demonstrations and pilot projects in a variety of settings. There are also some emerging studies that have been done on care management, specifically in primary care settings. For example, one study was completed in a multi-service health center in New York City in which medical assistants were trained as health coaches to provide care management services such as chronic disease management, self-management, and support and facilitation of behavior change. The medical assistants used the center’s electronic health record to track and follow their assigned patients. The clinical results showed statistically significant improvements in the percentage of patients with diabetes with control of their blood sugar levels, blood pressure, and cholesterol. The financial results showed that patients who were enrolled in this program cost 17% less per member per month than those who were not enrolled, and the emergency room costs were 50% lower.

Care management has the ability to facilitate better care and improved outcomes through timely communication and information sharing. This service should be holistic in nature, thus allowing for medical and non-medical issues to be addressed with appropriate services. If administered correctly, care management can clearly result in improved overall care coordination, specifically clinical outcomes in conjunction with reduced healthcare costs.

Coordinating Care for a Very Special Population

Coordinating care is difficult under the best of circumstances in the fragmented, helter-skelter world of U.S. healthcare. It is even more difficult when primary care providers and their specialist consultants practice in different organizations many miles apart, and patients can be medically or socially complex. Obtaining specialty care is often a problem for safety net providers and patients, and incarcerated patients are no exception. A fascinating effort to obtain and coordinate specialty referrals for prisoners began in Oklahoma, and is now spreading to other states.

Medical care for the Oklahoma prison system relies on primary care providers who see patients in the prison and refer to outside specialists. Specialists at the University of Oklahoma agreed to provide consultative care for prisoners across the state, but the demands challenged the University’s specialty care capacity and the Department of Corrections’ budget. The expenses for a specialty visit for a prisoner included transportation and security in addition to the medical care costs. Enter Dr. David Kendrick, a University of Oklahoma faculty member, who had developed an electronic referral system called Doc2Doc. His web-based e-referral system helps structure the information flowing between referring physician and consultant so that referring providers know what information and test results specialists want prior to seeing the patient, and specialists better understand the reasons for the referral and the referring physicians’ expectations for follow-up care.

Doc2Doc also provides a secure, asynchronous, HIPAA compliant way for referring and consulting providers to communicate with each other. This led Dr. Kendrick and colleagues to explore the potential of using the e-referral system to meet the needs of the patient and referring physician WITHOUT THE SPECIALIST SEEING THE PATIENT—what has been labeled a virtual consultation. Both the Department of Corrections (DOC) and the University shared a need to reduce the demand for face-to-face specialty visits for prisoners, but the potential loss of revenue for the specialty services had to be addressed. The parties agreed that the DOC would pay specialists $50 to review a referral request and either provide consultative support electronically, or arrange a face-to-face specialist visit. The prison e-consultation system ultimately led to an approximate 50% reduction in specialty visits for DOC inmates with no apparent reduction in quality of care. To date, over 100,000 e-consultations have taken place and the system has spread to other states.

Although involving a very special population and care system, the Oklahoma experience may have important lessons for safety net providers in general, who often have difficulties obtaining specialty care for their patients. It began with an agreement between a primary care provider (DOC) and a specialty care provider (University of Oklahoma) that recognized and addressed the financial challenges of both parties. The success of the agreement depended on three things:

1. Electronic connection among providers that enables the timely transmission of appropriate patient information;
2. The ability for referring and consulting providers to engage in interactive communication; and,
3. A business model that encourages both parties to prevent unnecessary face-to-face specialty visits.

A very similar program of e-referral has been established for safety net clinics in San Francisco. Careful evaluation of that system has indicated enhanced satisfaction among both primary care and specialty providers, reduced face-to-face visits, and satisfied patients.1-3

Community Health Centers of Lane County, Oregon Improve Mental Health Care Coordination

Community Health Centers of Lane County (CHCLC) is a federally-qualified health center (FQHC) located in Springfield/Eugene, Oregon. The clinic serves almost 16,000 patients, 650 of whom are actively receiving a combination of behavioral health services. This subset of the patient population is predominately severely and persistently mentally ill (SPMI). These patients are at high-risk for poor health outcomes and research demonstrates patients with severe mental illness die 25 years sooner than the general patient population. The most common diagnoses for this subset at the CHCLC are schizophrenia and bipolar disorder; many are dually diagnosed with substance abuse disorders as well. Almost all patients are either uninsured or are Medicaid or Medicare beneficiaries.

CHC of Lane County leadership identified several challenges impeding their ability to properly serve their patients with behavioral healthcare needs, who can require a disproportionate amount of staff time and can add challenges to the practice processes. First, there were inadequate processes and staff in place to provide for the behavioral healthcare needs of their primary care patients. Mental health and primary care providers traditionally worked in silos and communication about shared patients was virtually non-existent.

CHCLC providers expressed a desire for greater accessibility to counseling staff and psychiatric consults, and leadership believed that these services should be available on-site; as the fiscal reality, as well as the culture of the community, makes traditional mental health services difficult to access.

In 2005, CHCLC management brought a mental health specialist into the primary care practice. The therapist had an easily accessible office and provided brief behavioral interventions, consulted regarding resources, and offered supportive counsel to clients struggling to incorporate changes in their lives.

Then, in 2008, a satellite primary care office was co-located within the county's community mental health program. A primary care provider, medical assistant, and an office assistant are now located in this office. Co-location has resulted in immediate benefits in the number of shared patients with chronic health issues, as well as acute care needs. As a result, the number of documented shared patients between behavioral health and primary care jumped from 132 to 648 within two years.

The clinic's CEO, Jeri Weeks, is excited that patient outcomes are improving because of the changes in care coordination. "We've made medical diagnoses of diabetes, heart disease, and even cancer that had gone untreated. The medical and mental health clinicians began to see the value in caring for patients collaboratively. The medical providers joined case management meetings with the mental health providers allowing for formal, as well as informal, coordination of care," she says.
Knowledge from the Field

Denver Health Improves Referrals at Westside Pediatric Clinic

Denver Health operates eight clinics in its system, and is undergoing a system-wide push to improve care coordination across its sites. The Denver Health Westside Pediatric and Teen Clinic handles 27,000 patient visits per year for its 80% Hispanic patient population. When staff at the clinic wanted to learn what percentage of patients referred for developmental evaluation services were seen by a specialist, they found it was very difficult to track. They wanted to find a better way to “close the loop” on Early Intervention services where they suspected referrals were falling through the cracks.

This prompted a decision to implement a referral tracking system. To do this, clinical staff worked with the electronic health services (EHS) department to adapt an existing intranet-based tool. The system was engineered to track outside medical referrals and internal referrals to various care coordination resources linked to the Denver Health system.

Two additional care coordination changes were implemented as part of the improvement push: creating a Children with Special Health Care Needs (CSHCN) Registry combined with a strong push to use an existing asthma registry; and developing a referral handout for parents to provide contact and logistical information when referred for specialty care.

Before the referral system was created, there was no central repository to track referral outcomes. Providers had various methods and systems for tracking patients that were inefficient—for example, file folders, patient stickers on a piece of paper, etc.

“We wanted to stop children from falling through the cracks, and for providers to know what happened to referrals. We used a year-long quality improvement process with the Toyota Lean method, and the new system makes work easier for providers,” says Dr. Heather Varnell, Westside pediatrician.

The outcomes from the changes are already improving patient care. Evidence of increased process outcomes. Classification of asthma severity increased from 39% to 88% over a 12-month period, showing the new system has dramatically shortened the response time for managed care patients and ensured better efficiency and parent satisfaction. Turnaround time has been reduced for an authorization from up to two weeks to one or two days—or with an e-mail or call, to no wait at all.

Staff satisfaction is evident, too. “We are working better together as a team, which has helped us to provide better care for our patients. The emphasis on having the right person do the right job is great. I’m being given requests to contact patients to schedule needed appointments instead of the medical assistants,” says Celina Magallenes.

“Creating registries for children with chronic conditions and having an electronic referral tool to make and monitor the status of both external and internal referrals within our integrated system has allowed me to proactively reach out to patients for ongoing needs and to better help those who have fallen through the cracks. I feel like I can provide better care to these needier patients than I was doing before,” says Steve Vogler, Westside team leader.
Care Coordination, referring to referral or transition management, includes non-clinical but important functions such as providing information and logistical help to referred patients, assuring timely and effective transfer of patient information, and tracking referrals and transitions. Some patients are more complex, with co-morbidities, and require more intensive clinical care management in addition to logistical and informational support. In most practice panels, a large percentage of the patients will at some point be referred or hospitalized and need care coordination services, however, only a small subset of the most acutely or chronically ill patients will benefit from clinical care management services. This article discusses how EHR tools can support care through the logistical, clinical, and patient support and management services that comprise care management and clinical care management. To learn more about care coordination and care management, click here.

Care management spans preventive and chronic illness care as well as the coordination of services between hospitals or emergency departments and primary care. Much of what falls under the rubric of care management, including patient education, can be most efficiently delivered using evidence-based standardized protocols that non-physician care-team members are capable of executing in a wide range of settings. Research shows that when adequate resources are dedicated to population management, group visits, patient self-management support groups, and other advanced techniques, care management activities improve outcomes without increasing overall costs. Most clinics, however, operate in an environment in which the only services that are reimbursed for are those a provider delivers during an office visit. Thus the care management activities chosen for discussion here are ones that can be performed in the course of a routine office visit with minimal additional resources.

**Barriers to Care Management**

Office visits are built around a business model called a “solution shop” in which an expert, in this case the doctor, is expected to diagnose and develop a unique solution to each patient’s unique problem. Under this business model the expert may hire assistants, but only the expert is paid, based on the difficulty of the case. This system, which relies on the skill and intuition of the expert, is well designed for the diagnostic process, but not well designed for other processes, such as ongoing care for chronic illness. The activities of care management are far better suited to a completely different business model, called a “value-adding process”, in which skilled employees add value to the patient using standardized and evidence-based processes, for example:

- Routine monitoring of disease parameters.
- Routine testing and proactive outreach to address overdue tests.
- Treatment protocols to reduce risks.
- Patient education.
- Self-management support.
Although these activities are most effective when delivered by a team that the patient’s primary care provider (PCP) leads, it only rarely requires the skills of an expert diagnostician, and although some portions of the treatment plan may be individualized, the core principle is that process standardization allows the care team to minimize cost while guaranteeing quality. One of the benefits of working in a care team is that it allows the provider to continue using his/her diagnostic skills in the “solution shop mode” for patients who have unique diagnostic problems, while another part of the team can operate on more of an assembly-line mode to assure that check-lists are followed and that preventive or chronic care management services are reliably delivered. In addition, other members of the care team (nurses, educators, behaviorists, pharmacists, etc) have unique skills and specialized training in patient education, self-management support, and lifestyle coaching, all important activities in care management.

Workflow for Care Management Activity During an Office Visit

When designing care management workflows, the first question to ask is, “What is an effective workflow for the team to use to assure that appropriate care management occurs with each visit?” For example, the goal of a workflow might be for every patient who visits the clinic to leave with the highest priority care management issues addressed. Once goals are established, information management tools to support the workflow can be identified. Figure 2 identifies the key steps in such a workflow.

Figure 2: Key Steps in the Care Management Workflow
Step 1: Huddle. The team huddles briefly at the start of the day. This is a time to prioritize for each patient one or two care management issues to address during the visits. This can be done as the patient is being roomed and should be based on information in the patient’s EHR and/or information collected from the patient at the time of check-in. The patient may be overdue for a mammogram or pneumococcal vaccine, updating a chronic illness care plan, or a hospital discharge summary may need to be located. By quickly reviewing the chart of each scheduled patient using some common information organization tools, the team can identify the highest priority care management issues to address while the patient is in the clinic.

Step 2: Pre-visit Summary. When the patient arrives at the clinic for the visit, he/she should be given a one-page printout of information in the EHR summarizing his/her most important care management issues. This would include evidence-based preventive measures and recommendations for chronic illness care as well as a medication list. The pre-visit summary should be visually designed to help the patient quickly see what optimal management of his/her health issues should be, and to point out any gaps based on the information in the EHR. This is an opportunity for the patient to recall missing information that may close a gap. The pre-visit summary helps activate and engage the patient.

Step 3: Rooming. When the Medical Assistant rooms the patient he/she can enter missing information supplied by the patient thereby updating and increasing the accuracy of the EHR data.

Step 4: Order and Pend. The team can develop protocols for the Medical Assistant to follow in addressing items that actually are overdue. These protocols should authorize Medical Assistants to “order and pend” recommended tests or interventions in the EHR. This action prepares the clinical decision for the provider, who actually signs the order. By automating the process of gathering and organizing information in this standardized way the team can guarantee quality while freeing the provider’s time for activities that require his/her expert intuitive skills including guiding the patient in shared decision-making and attending to any diagnostic issues.

Step 5: Delivery. The patient has the opportunity to decline a treatment, but the workflow accomplishes the goal of assuring that the issue is addressed.
Information Flow

It is important to understand how information interacts with this workflow before choosing information organization tools to support it. Making a clinical decision, such as the decision to order an immunization, involves four distinct steps as shown in Figure 3.

Figure 3: Clinical Decision-Making Assembly Line

Step 1: The first step is gathering the information necessary to make the decision. Some of the information may be in the EHR, for example in the form of a previously ordered and administered immunization, or it might be in a historical immunizations field containing information the patient has about immunizations given elsewhere. Information may also come from other sources such as a State immunization registry, or a family member.

Steps 2 and 3: In the second step, raw information must be processed using such things as evidence-based guidelines or patient preferences, and then organized so that the third step, actually making the decision, can occur. When presented with complete and properly organized information, a provider can usually quickly determine the appropriate a clinical decision, which usually involves either placing an order or giving advice. If the information is gathered and organized without a clinical decision actually being made, the result is usually wasted effort.

Step 4: The fourth and final step in this assembly line is carrying out the order.1

Unlike the last step, which providers almost always delegate, the first two steps of gathering and organizing information usually don't begin until the provider enters the exam room. The strategy of delivering care management as a team allows the information gathering steps to be moved forward in the overall process, thereby improving efficiency and increasing the likelihood that essential services will not be forgotten. As much as possible, information gathering and sorting should be performed by other team members or by patients themselves. This frees up the provider to concentrate on what physicians do best, namely helping patients understand their options and make informed decisions about their health.
Information Tools to Support the Workflow

There are several kinds of tools in EHRs to help organize information for care management including graphs, flow sheets, dashboards, and rules engines. Graphs and flow sheets portray information, for example blood pressure or weight, by date in either a table or graphic display. Dashboards assemble different information common to a particular clinical topic, such as diabetes or preventive care, on a single screen so the user can quickly see the condition of the patient’s care management. A rules engine takes inputs from different data fields, for example demographic data on age and gender, and matches it with clinical data, such as date of most recent mammogram, and then applies a rule, for example a length of time after which the person would be overdue for screening. It then produces an output, usually in the form of an alert that the person is overdue, in this case for mammogram screening. The output of a rules engine is often displayed as part of a dashboard. Someone must enter inputs for the rules engine to define when screening should begin and whether to do it yearly or every two years. Once it is set up the rules engine processes the information automatically so the care team can quickly see if a mammogram should be ordered.

These tools help to organize existing data, and although they are subject to errors from missing information, they are very powerful in helping teams with care management in several ways. They save time by eliminating the tedious tasks of locating data scattered throughout the chart and organizing it so that a clinician can quickly make a decision. In addition, they make the decisions about what should be done for each patient more transparent so that non-physician team members can assist in many of the routine tasks of care management. Lastly, they serve to engage patients and their families in what is expected so that patients and the care team share common priorities for a visit. As shown in Figure 3, when clinical decision support and patient activation work together the result is improved clinical outcomes, partly due to better data capture, but more importantly because more patients are receiving the care we want them to receive.

While not all organizations will have all of the possible electronic information management tools to support all facets of care management, the basic workflow presented here for preventive and chronic illness care management (particularly the huddle) can be used with old fashioned information tools that can be replaced as the practice is able to invest in newer technology. Even if an interface with the emergency department hasn’t been set up yet, a team that is aware of a patient on their schedule who was seen in the ED last night can still decide in the huddle to call for a copy of the ED note before the patient arrives. The goal of care management information flow is to get the right information to the right person at the right time. Technology makes it easier to do this, but it doesn’t change the care team’s basic job.

NCQA 2011 PCMH Standards

NCQA released the new 2011 PCMH standards on January 31, 2011, with a subsequent package of revisions released on March 29, 2011. Compared to the prior 2008 standards, the 2011 standards are different in content, rigor, and scoring methodology.

The nine domains in the 2008 standards have been collapsed into six areas of focus, eliminating redundancy and re-aligning elements to be more consistent with the way in which clinical practices are structured and managed. These improvements make the standards much easier to follow and understand.

While the number of domains / elements has been reduced, the substantive content of the 2011 PCMH standards clarify, strengthen, and add to the former standards set. The following enhancements are noted:

1. There is a stronger focus on patient-centeredness throughout all domains.
2. Several elements address the integration of primary care and behavioral health.
3. Medication reconciliation is introduced into the standards.
4. The new standards are aligned with CMS Meaningful Use (of EHR) criteria.

The new 2011 standards are summarized below. A complete description of the standards can be found on the NCQA website.

PCMH 1: Enhance Access and Continuity
The practice provides access to culturally and linguistically appropriate routine care and urgent team-based care that meets the needs of patients/families.

PCMH 2: Identify an Manage Patient Populations
The practice systematically records patient information and uses it for population management to support patient care.

PCMH 3: Plan and Manage Care
The practice systematically identifies individual patients and plans, manages and coordinates their care, based on their condition and needs and on evidence-based guidelines.

PCMH 4: Provide Self-Care and Community Support
The practice acts to improve patients’ ability to manage their health by providing a self-care plan, tools, educational resources and ongoing support.

PCMH 5: Track and Coordinate Care
The practice systematically tracks tests and coordinates care across specialty care, facility-based care and community organizations.

PCMH 6: Measure and Improve Performance
The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality efficiency and patient experience.
New Scoring Algorithm

The new 2011 NCQA PCMH standards are scored using a similar 3-level recognition structure, with point allocation as noted in the table below. Note that the point distribution has been changed such that a clinical practice must attain more points to attain Level 1 under the 2011 standards than in the past. In addition, the 2011 standards require that all six “must-pass” elements must be met in order to attain the minimum level of recognition (Level 1), whereas in the 2008 standards, Level 1 could be attained with 5 of the 10 must-pass elements met.

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The Path to NCQA PCMH Recognition

As of April 30, 2011, NCQA reported that over 10,000 clinicians, representing 2200+ practices in 45 states, have now attained recognition as patient-entered medical homes. The Safety Net Medical Home Initiative is supporting 31 practices achieve recognition and 12 practices have already attained recognition – all at level 3.

Opportunities for Safety Net Providers

Safety net providers now have an expanded opportunity to obtain NCQA PCMH recognition, through either the Federally Qualified Health Center Advanced Primary Care Practice (FQHC APCP) Demonstration or the Patient-Centered Medical/Health Home Initiative. Both the Demonstration and the Initiative provide technical assistance and funding for NCQA recognition fees. Both projects are working to show how the patient-centered medical home model can improve quality of care, promote better health and lower costs.

In the FQHC APCP Demonstration, practices will also receive a $6 per member per month payment. For more information on the FQHC APCP Demonstration, click here; for more information on the PMCHHI, click here.

Tools/Resources:

- 2011 NCQA PCMH Standards (NCQA)
- NCQA 2011 Medical Home Assessment Tool (Primary Care Development Corporation)
- 2011 NCQA PCMH Document Tracking Tool (Qualis Health)
This is a product of the Safety Net Medical Home Initiative, which is supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff. The Initiative also receives support from the Colorado Health Foundation, Jewish Healthcare Foundation, Northwest Health Foundation, The Boston Foundation, Blue Cross Blue Shield of Massachusetts Foundation, Partners Community Benefit Fund, Blue Cross of Idaho, and the Beth Israel Deaconess Medical Center. For more information about The Commonwealth Fund, refer to www.cmwf.org.

The objective of the Safety Net Medical Home Initiative is to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative is administered by Qualis Health and conducted in partnership with the MacColl Institute for Healthcare Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org/