AAPCHO

Practice Transformation Resources

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EXPLAINING MEDICAL HOME TO PATIENTS

In order for medical homes at community health centers to be authentically “patient-centered”, it is vital that patients understand the roles and responsibilities of their primary care providers and all the members of their health care team, and their own roles and responsibilities as an informed and engaged patient.

National Partnership for Women & Families, Patient Brochure and Consumer Advocate Guides on Medical Homes
http://www.nationalpartnership.org/site/PageServer?pagename=issues_health_home

Patient-Centered Primary Care Collaborative, Video Introduction to Medical Home
http://www.pcpcc.net/about/medical-home

Patient-Centered Primary Care Collaborative, Brochure for Patients: What is a Medical Home?
http://moo.pcpcc.net/files/english_pcmh_brochure__0.pdf

ASSIGNING PATIENTS TO PROVIDERS

One of the first steps in establishing medical homes in a community health center is confirming the ongoing, continuous relationship between a primary care provider (assisted by a care team) with each patient. The providers can then be reasonably expected to take responsibility for all their assigned patients and their health care outcomes.

Medical Home Safety Net Initiative, *Resources on Empanelment*
http://www.safetynetmedicalhome.org/change-concepts/empanelment

Wagner EH, Coleman K, Reid RJ, Phillips K, Sugarman JR. *Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes*, The Commonwealth Fund (2012)
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patientcentered_med_home_v2.pdf

Willard R, Bodenheimer T. *The Building Blocks of High-Performing Primary Care: Lessons from the Field*, California HealthCare Foundation (2012)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingBlocksPrimaryCare.pdf

BALANCING PROVIDER PANELS

It is important that each primary care provider at the community health center feel that they have an appropriate and fair share of patients assigned to them. Provider panels need to be balanced based on the provider's schedule (full or part-time), with an appropriate mix of patients with complex and/or multiple conditions.

Medical Home Safety Net Initiative, *Resources on Empanelment*
http://www.safetynetmedicalhome.org/change-concepts/empanelment

Wagner EH, Coleman K, Reid RJ, Phillips K, Sugarman JR. *Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes*, The Commonwealth Fund (2012)
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patientcentered_med_home_v2.pdf

Willard R, Bodenheimer T. *The Building Blocks of High-Performing Primary Care: Lessons from the Field*, California HealthCare Foundation (2012)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingBlocksPrimaryCare.pdf

CREATING CARE TEAMS

One of the workflow changes required for effective medical homes is the creation of care teams to support each primary care provider. These care teams must have the appropriate education, training, skills, and experience to function as a complementary and interdisciplinary team.

Medical Home Safety Net Initiative, *Resources on Continuous Team-Based Healing Relationships*
http://www.safetynetmedicalhome.org/change-concepts/continuous-team-based-healing-relationships

Wagner EH, Coleman K, Reid RJ, Phillips K, Sugarman JR. *Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes*, The Commonwealth Fund (2012)
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patientcentered_med_home_v2.pdf

Willard R, Bodenheimer T. *The Building Blocks of High-Performing Primary Care: Lessons from the Field, California HealthCare Foundation* (2012)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingBlocksPrimaryCare.pdf

Bodenheimer T. *Building Teams in Primary Care: Lessons Learned*, California HealthCare Foundation (2007)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingTeamsInPrimaryCareLessons.pdf

Bodenheimer T. *Building Teams in Primary Care: Fifteen Case Studies*, California HealthCare Foundation (2007)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingTeamsInPrimaryCareCaseStudies.pdf

Veterans Health Administration, *Engaging the Team in the Idea of a Patient-Centered Medical Home and Analyzing Tasks to Redesign Your Team for the Patient-Centered Medical Home* (fact sheets)
http://www.va.gov/primarycare/pcmh/

Taylor EF, Machta RM Meyers DS, Genevro J, Peikes DN. Enhancing the primary care team to provide redesigned care: The roles of practice facilitators and care managers. *Ann Fam Med* (2013);11(1):80-83

CREATING CARE TEAMS (cont.)

Agency for Healthcare Research and Quality, *Developing and Running a Practice Facilitation Program for Primary Care Transformation: A How-To Guide* (2011) http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_implementing_the_pcmh___practice_facilitation_v2

Baskerville NB, Liddy C, Hogg W. Systematic review and meta-analysis of practice facilitation within primary care settings. *Ann Fam Med.* (2012); 10(1): 63-74

Grumbach K, Bainbridge E, Bodenheimer T. *Facilitating improvement in primary care: The promise of practice coaching*, The Commonwealth Fund (2012)
http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Jun/1605_Grumbach_facilitating_improvement_primary_care_practice_coaching.pdf

California HealthCare Foundation, *Team Meetings in a Clinical Environment* (2009)
http://www.chcf.org/publications/2009/06/video-on-team-meetings-in-a-clinical-environment

TRAINING CARE TEAMS

Members of the care team may need additional training and ongoing support to fulfill their enhanced roles in a medical home.

University of California San Francisco Center for the Health Professions, *Physician Assistant and Nurse Practitioner Staffing Patterns in California's Licensed Community Clinics: 2005 – 2008* (2010)
http://futurehealth.ucsf.edu/Content/8866/2010-06_Physician_Assistant_and_Nurse_Practitioner_Staffing_Patterns_in_Californias_Licensed_Community_Clinics_2005-2008.pdf

University of California San Francisco Center for the Health Professions, *Medical Assistants in Community Clinics: Perspectives on Innovation in Role Development (*2010)
http://www.futurehealth.ucsf.edu/Content/8866/2010-06_Medical_Assistants_in_Community_Clinics_Perspectives_on_Innovation_in_Role_Development.pdf

University of California San Francisco Center for the Health Professions, *The Utilization of Medical Assistants in California's Licensed Community Clinics* (2009)
http://www.futurehealth.ucsf.edu/Content/8877/2009-07_The_Utilization_of_Medical_Assistants_in_California_s_Licensed_Community_Clinics.pdf

Ngo V, Hammer H, Bodenheimer T. Health coaching in the teamlet model: a case study. *J Gen Intern Med.* (2010);25(12):1375-1378

Bodenheimer T, Laing BY. The teamlet model of primary care. *Ann Fam Med.* (2007);5(5):457-461

BTW Informing Change, *The Bridging Role of Community Health Promoters* (2010)
http://www.communityclinics.org/content/general/detail/1019

ENHANCED ACCESS

In order to ensure optimal access to care in a medical home, appointment systems and scheduling may need to be modified to increase the availability of same-day and next-day appointments, and to reduce waiting times for appointments.

Medical Home Safety Net Initiative, *Resources on Enhanced Access*
http://www.safetynetmedicalhome.org/change-concepts/enhanced-access

Wagner EH, Coleman K, Reid RJ, Phillips K, Sugarman JR. *Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes*, The Commonwealth Fund (2012)
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patientcentered_med_home_v2.pdf

Willard R, Bodenheimer T. *The Building Blocks of High-Performing Primary Care: Lessons from the Field*, California HealthCare Foundation (2012)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingBlocksPrimaryCare.pdf

Murray M, Bodenheimer T, Rittenhouse D, Grumbach K. Improving timely access to primary care: case studies of the advanced access model. *JAMA.* (2003);289(8):1042-1046

Tantau C. Accessing patient-centered care using the advanced access model. *J Ambul Care Manage.* (2009);32(1):32-43

FUNDING ENCOUNTERS THAT ARE NOT FACE-TO-FACE

The health care and services that are provided in many routine clinic visits can be provided through encounters that are not in-person, face-to-face encounters, such as telephone consultations or through electronic mail ("e-visits"). While these encounters are often not currently billable, they will increasingly be important alternatives to providing optimal care to all patients in a medical home.

Eads M Virtual office visits: A reachable and reimbursable innovation. *Fam Pract Manag.* (2007); 14(9):20-22
http://www.aafp.org/fpm/2007/1000/p20.pdf

Agency for Healthcare Research and Quality Innovations Exchange, Solo Physician's Use of Virtual and Phone Visits, Same-Day Appointments, and Extended In-Person Visits Leads to High Patient Satisfaction and Improved Chronic Disease Outcomes
http://innovations.ahrq.gov/content.aspx?id=2196

American College of Physicians, Communicating with Patients Electronically (2008)
http://www.acponline.org/running_practice/technology/comm_electronic.pdf

CONDUCTING COMPREHENSIVE HEALTH ASSESSMENTS

In order for patients to feel that their medical home provider knows them individually, treats them as a whole person, and address all their health care needs. Medical homes must conduct comprehensive health assessments that include detailed medical, social, and family histories.

Individual Health Education Behavioral Assessments (available in English, Chinese, Vietnamese, Hmong, Lao, Spanish, Russian)
http://lacare.org/providers/resources/stayinghealthyforms

American Academy of Family Physicians, *Family Practice Management Toolbox: Patient Surveys/Questionnaires*
http://www.aafp.org/online/en/home/publications/journals/fpm/fpmtoolbox.html#Parsys20275

CREATING CARE PLANS

Developing and using an individualized care plan for each patient ensures that the medical home and the patient have mutually understood all the health care needs for that patient. This helps develop realistic, achievable goals of treatment and improvement for each diagnosis along with establishing conditions that have been agreed to by both parties.

DeWalt, DA, Callahan, LF, Hawk, VH, Broucksou, KA, Hink, A, Rudd, RE, Brach, C. *Health Literacy Universal Precautions Toolkit*, Agency for Healthcare Research and Quality (2010)
http://www.ahrq.gov/qual/literacy/healthliteracytoolkit.pdf

Weiss, BD. *Health literacy and patient safety: Help patients understand - Manual for clinicians*, American Medical Association (2007)
http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf

Centers for Disease Control and Prevention, Asthma Action Plans
http://www.cdc.gov/asthma/tools_for_control.htm

Kaiser Permanente Diabetes Care Plan
http://www.permanente.net/homepage/kaiser/pdf/62895.pdf

American Academy of Family Physicians, *Family Practice Management Toolbox: Disease Management: Asthma*
http://www.aafp.org/online/en/home/publications/journals/fpm/fpmtoolbox.html#Parsys97912

American Academy of Family Physicians, *Family Practice Management Toolbox: Disease Management: Diabetes*
http://www.aafp.org/online/en/home/publications/journals/fpm/fpmtoolbox.html#Parsys9810

POPULATION HEALTH MANGAGEMENT

One of the goals of medical homes is to enable providers to know and analyze the health care outcomes of all patients and identify both overall needs for quality improvement as well as specific patients that may need additional attention and support.

Medical Home Safety Net Initiative, *Resources on Organized Evidence-Based Care*
http://www.safetynetmedicalhome.org/change-concepts/organized-evidence-based-care

Wagner EH, Coleman K, Reid RJ, Phillips K, Sugarman JR. *Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes*, The Commonwealth Fund (2012)
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patientcentered_med_home_v2.pdf

Willard R, Bodenheimer T. *The Building Blocks of High-Performing Primary Care: Lessons from the Field*, California HealthCare Foundation (2012)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingBlocksPrimaryCare.pdf

Wagner EH, et al. Improving chronic illness care: Translating evidence into action. *Health Aff.* (2001);20(6):64-78

Agency for Healthcare Research and Quality, Computerized Disease Registries
http://healthit.ahrq.gov/portal/server.pt?open=514&objID=5554&mode=2&holderDisplayURL=http://wci-pubcontent/publish/communities/k_o/knowledge_library/key_topics/health_briefing_11092009031502/computerized_disease_registries.html

Robert Wood Johnson Foundation Aligning Forces for Quality, *Practice Coaching Manual*
http://forces4quality.org/practice-coaching-program-manual

POPULATION HEALTH MANGAGEMENT (cont.)

Weir RC, Emerson HP, Tseng W, Chin MH, Caballero J, Song H, Drum M. Use of enabling services by Asian American, Native Hawaiian, and other Pacific Islander patients at 4 community health centers. *Am J Public Health* (2010);100: 2199-2205

Association of Asian Pacific Community Health Organizations, *Impact of Enabling Services Utilization on Health Outcomes* (2009)
http://enablingservices.aapcho.org/

Association of Asian Pacific Community Health Organizations. *Evaluation of Culturally Appropriate Community Health Education on Diabetes Outcomes* (2008)
http://enablingservices.aapcho.org/

Fisher TL, et al. Cultural leverage: Interventions using culture to narrow racial disparities in health care. *Med Care Res Rev.* (2007); 64(5): 243S-282S

MANAGING COMPLEX PATIENTS

Patients with complex and/or multiple diagnoses and conditions may need additional support to manage their health, medications, treatments, tests, and daily functioning. Family members and caregivers may need to be more engaged in supporting the patient's care plan and may need more communication and coordination with the medical home.

Mathematica Policy Research, Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions, Agency for Healthcare Research and Quality (2012)
http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh___home/1483/pcmh_tools___resources_coordinated_care_v2

Mathematica Policy Research, Ensuring that Patient Centered Medical Homes Effectively Serve Patients with Complex Needs, Agency for Healthcare Research and Quality (2011)
http://pcmh.ahrq.gov/portal/server.pt/community/pcmh___home/1483/PCMH_Tools%20&%20Resources_Comprehensive%20Care_v2

SUPPORTING PATIENT SELF-MANAGEMENT

One of the principles of the "patient-centered" medical home is to provide more tools and support for patients to know, understand, and follow their care plans through self-management skills. Medical homes need to provide educational, emotional, and social support for patient self-management.

Institute for Healthcare Improvement, *Partnering in Self-Management Support: Toolkit for Clinicians* (2009)
http://www.ihi.org/knowledge/Pages/Tools/SelfManagementToolkitforClinicians.aspx

Medical Home Safety Net Initiative, *Resources on Patient-Centered Interactions*
http://www.safetynetmedicalhome.org/change-concepts/patient-centered-interactions

Wagner EH, Coleman K, Reid RJ, Phillips K, Sugarman JR. *Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes*, The Commonwealth Fund (2012)
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patientcentered_med_home_v2.pdf

Institute for Family- and Patient-Centered Care, *Partnering with Patients and Families To Design a Patient- and Family-Centered Health Care System: Recommendations and Promising Practices* (2008)
http://www.ipfcc.org/pdf/PartneringwithPatientsandFamilies.pdf

Institute for Family- and Patient-Centered Care, *Advancing the Practice of Patient- and Family-Centered Care: How to Get Started...* (2008)
http://www.ipfcc.org/pdf/getting_started.pdf

Bodenheimer T, Abramowitz S. *Helping Patients Help Themselves: Implementing Self-Management Support*, California HealthCare Foundation (2010)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HelpingPtsHelpThemselvesImplementSelfMgtSupport.pdf

California HealthCare Foundation, *Self-Management Support Training Materials* (2009)
http://www.chcf.org/publications/2009/09/selfmanagement-support-training-materials

SUPPORTING PATIENT SELF-MANAGEMENT (cont.)

Kanaan SB. *Promoting Effective Self-Management Approaches to Improve Chronic Disease Care: Lessons Learned*, California HealthCare Foundation (2008)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20SelfMgmtLessonsLearned.pdf

Emont S. *Evaluation of Team Up for Health Initiative*, California HealthCare Foundation (2011)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/E/PDF%20EvaluationTeamUpForHealth.pdf

Mathematica Policy Research, *Engaging Patients and Families in the Medical Home*, Agency for Healthcare Research and Quality (2010)
http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_tools___resources_patient-centered_v2

Agency for Healthcare Quality and Research, *The Patient-Centered Medical Home: Strategies to Put Patients at the Center of Primary Care* (2011)
http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/pcmh_tools___resources_patient-centered_v2

Braddock CH, et al. Informed decision making in outpatient practice: time to get back to basics. *JAMA (*1999);282(24):2313-2320.

Hibbard JH, Mahoney E. Toward a theory of patient and consumer activation. *Patient Educ Couns.* (2010);78(3):377-381

O'Connor AM, et al. Toward the 'tipping point': Decision aids and informed patient choice. *Health Aff* (2007);26(3):716-725.

Wood SH, et al. Promoting informed choice: transforming health care to dispense knowledge for decision making. *Ann Intern Med.* (2005);143(4): 293-300.

Kreuter MW, et al. Achieving cultural appropriateness in health promotion programs: targeted and tailored approaches. *Health Educ Behav.* (2003); 30(2):133-146

California Healthcare Foundation, *Sharing the Care: The Role of Family in Chronic Illness* (2009)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/F/PDF%20FamilyInvolvement_Final.pdf

Maizes V, Rakel D, Niemiec C. Integrative medicine and patient-centered care. *Explore* (2009);5(5):277-289

SAMPLE: Self-Management Support Tool
http://www.ihi.org/knowledge/Pages/Tools/PatientPlanningWorksheet.aspx

PROVIDING PATIENT EDUCATION MATERIALS

A traditional way of supporting patient understanding and engagement is providing patient education materials. Ensuring that materials are linguistically accessible, culturally appropriate, and available in multiple formats is especially important for patients at community health centers.

Network of National Libraries of Medicine, Consumer Health Information in Many Languages Resources (materials available in Chinese, Korean, Vietnamese, Cambodian/Khmer, Hmong, Laotian, Thai, and other languages)
http://nnlm.gov/outreach/consumer/multi.html

Care 1st Health Plan, Patient Health Education Materials in Multiple Languages
https://www.care1st.com/ca/providers/health-education/health-education-materials.asp

CREATING A PATIENT PORTAL

As community health centers implement and utilize electronic health records, patients (and their family members and caregivers) will be able to access more health information such as medication lists, lab results, clinical visit summaries, and discharge instructions. This increased access to health information will assist the patients in being more informed and engaged in their care plan. In addition, some functions such as making appointments and ordering prescription medication refills can be done more efficiently through an electronic patient portal.

California HealthCare Foundation, *Safety Net Providers Bring Patients Online* (2009)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20SafetyNetPatientsOnline.pdf

Emont S. *Measuring the Impact of Patient Portals*, California HealthCare Foundation (2011)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MeasuringImpactPatientPortals.pdf

California HealthCare Foundation, *Helping Patients Plug In: Lessons in the Adoption of Online Consumer Tools* (2008)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HelpingPatientsPlugIn.pdf

Ngo-Metzger Q, Hayes GR, Chen Y, Cygan R, Garfield CF. Improving communication between patients and providers using health information technology and other quality improvement strategies: Focus on Asian Americans. *Med Care Res Rev* (2010); 67(5 Suppl): 231S-245S

Tang PC, Lansky D. The missing link: bridging the patient-provider health information gap. *Health Aff.* (2005);24(5):1290-1295

California HealthCare Foundation, *How Smartphones are Changing Health Care* (2010)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HowSmartphonesChangingHealthCare.pdf

CREATING A PATIENT PORTAL (cont.)

PriceWaterhouseCoopers Health Research Institute, *Healthcare Unwired: New Business Models Delivering Care Anywhere* (2010)
http://pwchealth.com/cgi-local/hregister.cgi?link=reg/healthcare-unwired.pdf

California HealthCare Foundation, *National Survey of Consumers about Health Information Technology* (2010)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20ConsumersHealthInfoTechnologyNationalSurvey.pdf

Millery M, Kukafka R. Health information technology and quality of health care: strategies for reducing disparities in underresourced settings. *Med Care Res Rev.* (2010);67(5 Suppl):268S-298S

Bau I. Connected for health: The potential of health information and communications technologies to reduce health care disparities. *Natl Civic Rev.* (2011); 100(3):15-18

Office of National Coordinator for Health Information Technology, Direct Project
http://directproject.org/content.php?key=overview

TRANSITIONING FROM CURRENT PAPER MEDICAL RECORDS TO ELECTRONIC HEALTH RECORDS

As community health centers implement electronic health records, they must adjust their workflows and implement other changes to support the ongoing electronic documentation of data and use of electronic data for both individual and population level clinical care and management.

Agency for Healthcare Research and Quality, *Workflow Assessment for Health IT*
http://healthit.ahrq.gov/portal/server.pt/community/health_it_tools_and_resources/919/workflow_assessment_for_health_it_toolkit/27865

Agency for Healthcare Research and Quality, *Necessary But Not Sufficient: The HITECH Act and Health Information Technology's Potential to Build Medical Homes* (2010)
http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/ahrq_commissioned_research

Patient-Centered Primary Care Collaborative, *Transforming Patient Engagement: Health IT in the Patient Centered Medical Home* (2010)
http://www.pcpcc.net/sites/default/files/media/pep-report.pdf

Patient-Centered Primary Care Collaborative, *Meaningful Connections: A Resource Guide for Using Health IT to Support the Patient-Centered Medical Home* (2009)
http://www.pcpcc.net/sites/default/files/media/cehia_mc.pdf

Bates DW, Bitton A. The future of health information technology in the patient-centered medical home. *Health Aff.* (2010);29(4):614-621

DOCUMENTING DEMOGRAPHIC DATA

Given the diversity of patients served by community health centers, it is especially important that granular demographic data is collected and documented by medical homes.

U.S. Department of Health and Human Services Office of Minority Health, *Data Collection Standards for Race, Ethnicity, Primary Language, Sex, and Disability Status* (2011)
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

Institute of Medicine, *Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement* (2009)
http://www.iom.edu/datastandardization

Wynia M, Hasnian-Wynia R, Hotze TD, Ivey SL. *Collecting and using race, ethnicity, language data in ambulatory settings*, Commission to End Health Care Disparities (2011)
http://www.ama-assn.org/resources/doc/public-health/cehcd-redata.pdf

Health Research and Education Trust, *Toolkit on Collecting Race, Ethnicity, and Primary Language Information from Patients*
http://www.hretdisparities.org/

U.S. Department of Health and Human Services Office of Minority Health, *Plan for Health Data Collection on Lesbian, Gay, Bisexual, and Transgender Populations* (2011)
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=209

Institute of Medicine, *Collection of Sexual Orientation and Gender Identity Data in Electronic Health Records* (2012)
http://www.iom.edu/Reports/2012/Collecting-Sexual-Orientation-and-Gender-Identity-Data-in-Electronic-Health-Records.aspx

USING CLINICAL DECISION SUPPORT

One of the benefits of using electronic health records is the ability for providers to quickly reference electronic clinical decision support to ensure that they are following clinical practice guidelines and best practices in clinical care.

Patient-Centered Primary Care Collaborative, *Clinical Decision Support in the Medical Home* (2010)
http://www.pcpcc.net/sites/default/files/media/clinical-decision.pdf

Medical Home Safety Net Initiative, *Resources on Organized Evidence-Based Care*
http://www.safetynetmedicalhome.org/change-concepts/organized-evidence-based-care

Wagner EH, Coleman K, Reid RJ, Phillips K, Sugarman JR. *Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes*, The Commonwealth Fund (2012)
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patientcentered_med_home_v2.pdf

Willard R, Bodenheimer T. *The Building Blocks of High-Performing Primary Care: Lessons from the Field*, California HealthCare Foundation (2012)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingBlocksPrimaryCare.pdf

LA Care Health Plan, *Matrix of Clinical Guidelines*
http://www.lacare.org/sites/default/files/files/2012%20CPG%20Source%20Matrix%20Rev%2010-3-12%20_2_.pdf

LA Care Health Plan, *Matrix of Preventive Health Guidelines*
http://www.lacare.org/sites/default/files/files/2012%20PHG%20matrix%202-24-12.pdf

American Academy of Family, *Physician Encounter Forms*
http://www.aafp.org/fpm/2006/0900/p63.html

IMPLEMENTING STANDING ORDERS

One technique to improve efficiency and ensure standardization of routine care processes is to use standing orders for routine medication refills and for periodic testing and screening. Standing orders empower members of the care team to continue ongoing routine care, anticipate the need to review updated tests, and ensure compliance with recommended preventive screenings.

Medical Home Safety Net Initiative, *Resources on Organized Evidence-Based Care*
http://www.safetynetmedicalhome.org/change-concepts/organized-evidence-based-care

Wagner EH, Coleman K, Reid RJ, Phillips K, Sugarman JR. *Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes*, The Commonwealth Fund (2012)
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patientcentered_med_home_v2.pdf

Willard R, Bodenheimer T. *The Building Blocks of High-Performing Primary Care: Lessons from the Field*, California HealthCare Foundation (2012)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingBlocksPrimaryCare.pdf

SAMPLE: St. Peter's Medical Clinic Standing Order for Diabetes
http://www.diabetesinitiative.org/resources/tools/documents/19-PROV-StandingOrdersMAPlannedvisit_web.pdf

ELECTRONIC PRESCRIBING

One of the functions of an electronic health records that will improve patient safety and the efficiency of care will be electronic prescribing that includes checks for drug-to-drug interactions as well as eligibility for health insurance coverage through formularies. Having electronic records of all prescriptions will also be invaluable in compiling comprehensive medication lists for each patient.

RAND Corporation, *Toolset for E-Prescribing Implementation in Physician Offices,* Agency for Healthcare Research and Quality (2011) http://healthit.ahrq.gov/portal/server.pt/community/health_it_tools_and_resources/919/a_toolset_for_e-prescribing_implementation_in_physician_offices/30594

American Academy of Family Physicians, *Family Practice Management Toolbox: Care Management* http://www.aafp.org/online/en/home/publications/journals/fpm/fpmtoolbox.html#Parsys60925

Grossman JM, Gerland A, Reed MC, Fahlman C. Physicians' experiences using commercial e-prescribing systems. *Health Aff* (2007);26(3):w393-w404

Weingart SN, et al. Assessing the value of electronic prescribing in ambulatory care: a focus group study. *Int J Med Inform* (2009);78(9):571-578

Center for Studying Health System Change, *Even When Physicians Adopt E-Prescribing, Use of Advanced Features Lag* (2010) http://www.hschange.com/CONTENT/1133/1133.pdf

CONDUCTING MEDICATION RECONCILIATION

Updated reconciliation of all medication prescribed for each patient is critical for effective treatment, especially after transitions of care such as a hospital discharge. Misunderstanding and inability to follow prescription medication instructions is a leading cause for avoidable hospital readmissions.

Patient-Centered Primary Care Collaborative, *Integrating Comprehensive Medication Management to Optimize Patient Outcomes* (2012) http://www.pcpcc.net/sites/default/files/media/medmanagement.pdf

Schnipper JL, et al. Effect of an electronic medication reconciliation application and process redesign on potential adverse drug events: a cluster-randomized trial. *Arch Intern Med.* (2009);169(8):771-780

PREPARING CLINIC VISIT SUMMARIES

Sharing a summary of each clinic visit that includes an updated problem or diagnosis list, updated medication list, next steps in the care plan (tests, referrals, updated health improvement goals), and any next appointment will assist the medical home in supporting patients in meeting the goals of the care plan.

Artz NH. Clinical summaries and meaningful use: A primer. *J Healthcare Info Mgt* (2011); 25(1):62-69
http://www.himss.org/files/HIMSSorg/content/files/Code%20101_Clinical%20summaries%20and%20meaningful%20use%20A%20primer_Artz_JHIM_W2011.pdf

American Academy of Family Physicians, *Family Practice Management Toolbox: Encounter Forms*
http://www.aafp.org/online/en/home/publications/journals/fpm/fpmtoolbox.html#Parsys99885

Greenhalgh T, et al. Adoption and non-adoption of a shared electronic summary record in England: a mixed-method case study. *BMJ.* (2010); 16(340):c3111

PREPARING CARE COORDINATION DOCUMENTS

Communicating and sharing essential health information about each patient among all that patient's providers is critical for improved care coordination. As care coordination documents are standardized and shared electronically, medical homes will have increased confidence that all of a patient's providers are working together to assist that patient.

Medical Home Safety Net Initiative, *Resources on Care Coordination*
http://www.safetynetmedicalhome.org/change-concepts/care-coordination

Wagner EH, Coleman K, Reid RJ, Phillips K, Sugarman JR. *Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes*, The Commonwealth Fund (2012)
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patientcentered_med_home_v2.pdf

Willard R, Bodenheimer T. *The Building Blocks of High-Performing Primary Care: Lessons from the Field*, California HealthCare Foundation (2012)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingBlocksPrimaryCare.pdf

Patient Centered Primary Care Collaborative, *Core Value, Community Connections: Care Coordination in the Medical Home* (2011)
http://www.pcpcc.net/sites/default/files/media/carecoordination_pcpcc.pdf

Center for Studying Health System Change, *Coordination of Care by Primary Care Practices: Strategies, Lessons and Implications* (2009)
http://www.hschange.com/CONTENT/1058/1058.pdf

McAllister JW, Presler E, Cooley WC. *Medical Home Practice-Based Care Coordination*, Center for Medical Home Improvement (2007)
http://www.medicalhomeimprovement.org/pdf/MHPracticeBasedCC-Workbook_7-16-07.pdf

PREPARING CARE COORDINATION DOCUMENTS (cont.)

Linked IPA, *Care Coordination Manual* (2010?)
http://www.patientphysiciancoop.com/sites/patientphysiciancoop.com/files/docs/ipabook/Care_Coordination_Manual.pdf

National Center for Medical Home Improvement, *Care Coordination Toolkit for Children with Special Health Care Needs* (2006)
http://www.medicalhomeinfo.org/downloads/pdfs/carecoordinationtoolkit06.pdf

Bodenheimer T. Coordinating care: A perilous journey through the health care system. *N Eng J Med.* (2008); 358(10):1064-1071

TRACKING LAB AND TEST RESULTS

As medical homes assume responsibility for the ongoing, continuous care of each patient, it is important to track lab and test results to ensure that tests and screenings are completed as recommended, and that abnormal results are identified and acted upon promptly.

White B. Four principles for better test tracking. *Fam Pract Manag.* (2002);9(7):41-44
http://www.aafp.org/fpm/2002/0700/p41.html

Burns KD. How can busy physicians better manage laboratory results. *Permanente J* (2003):7(4): 23-25
http://xnet.kp.org/permanentejournal/fall03/busy.pdf

TRACKING REFERRALS TO SPECIALISTS

Primary care medical homes also will be taking responsibility for following up with specialists and more proactively coordinating care among specialists to ensure that care plans are updated and consistent, and take into account the whole-person needs of that patient.

California HealthCare Foundation and Kaiser Permanente, *Specialty Care in the Safety Net: Efforts to Expand Timely Access* (2009)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20SpecialtyCareOverview.pdf

Kaiser Permanente and California HealthCare Foundation, *Specialty Care Initiative Evaluation Report* (2011)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20SpecialtyCareInitiativeEvaluation.pdf

Center for Community Health and Evaluation, *Roadmap for Referral: A Specialty Care Initiative Case Study on Embedding Guidelines into the Referral Process*, California HealthCare Foundation and Kaiser Permanente (2011)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20SCICaseStudyReferrals.pdf

Center for Community Health and Evaluation, *Healing Links: A Specialty Care Initiative Case Study on Integrating Care Coordination*, California HealthCare Foundation and Kaiser Permanente (2011)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20SCICaseStudyCareCoordination.pdf

Center for Community Health and Evaluation, *Building Provider Networks in West LA: A Specialty Care Initiative Case Study*, California HealthCare Foundation and Kaiser Permanente (2011)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20SCICaseStudyBuildingNetworks.pdf

Center for Community Health and Evaluation, *Healing Links: A Specialty Care Initiative Case Study on Increasing Primary Care Capacity in San Diego*, California HealthCare Foundation and Kaiser Permanente (2011)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20SCICaseStudyPCPCapacity.pdf

TRACKING REFERRALS TO SPECIALISTS (cont.)

Cook NL, et al. Access to specialty care and medical services in community health centers. *Health Aff* (2007);26(5):1459-1468

American Academy of Family Physicians, *Family Practice Management Toolbox: Referral Management*
http://www.aafp.org/online/en/home/publications/journals/fpm/fpmtoolbox.html#Parsys68837

EXCHANGING HEALTH INFORMATION WITH OTHER PROVIDERS

The use of electronic health records enable community health center medical homes to exchange health information about their patients with other health care providers that the patient needs, including pharmacies, labs, specialists, and hospitals, to improve the coordination and quality of health care. Local, regional, and state health information exchanges are being established to facilitate this exchange.

Medical Home Safety Net Initiative, *Resources on Care Coordination*
http://www.safetynetmedicalhome.org/change-concepts/care-coordination

Overhage JM. Health information exchange: 'Lex parsimoniae'. *Health Aff.* (2007);26(5):w595-w597

Edwards A, Hollin I, Barry J, Kachnowski S. Barriers to cross-institutional health information exchange: a literature review. *J Healthc Inf Manag.* (2010);24(3):22-34

IMPROVING CARE TRANSITIONS

Since community health centers do not provide in-patient health care services, it is critical to ensure that transitions of care for their patients are made effectively and efficiently, especially after hospitalizations (both unplanned emergencies as well as planned hospitalizations).

Schall M, Coleman E, Rutherford P, Taylor J. *Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations*, Institute for Healthcare Improvement (2009)
http://www.ihi.org/knowledge/Pages/Tools/HowtoGuideImprovingTransitionsHospitaltoOfficePracticeReduceRehospitalizations.aspx

National Coordinating Center for Integrating Care for Populations and Communities
http://www.cfmc.org/integratingcare/

Care Transitions Intervention
http://www.caretransitions.org

Community-Based Care Transition Program
http://www.innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP/index.html?itemID=CMS1239313

INTEGRATING BEHAVIORAL HEALTH

Many community health centers have worked to integrate their mental health and behavioral health services with their medical care services. Identifying and effectively treating mental health and substance abuse issues are essential to providing the whole-person care expected of medical homes.

National Council for Community Behavioral Healthcare, *Behavioral Health/Primary Care Integration in the Person-Centered Healthcare Home* (2009)
http://www.thenationalcouncil.org/galleries/resources-services%20files/Integration%20and%20Healthcare%20Home.pdf

Agency for Healthcare Research and Quality, *Integrating Mental Health Treatment into the Patient Centered Medical Home* (2010)
http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/ahrq_commissioned_research

Yeung A, et al. Culturally sensitive collaborative treatment for depressed Chinese Americans in primary care. *Am J Public Health* (2010)100: 2397-2402

SAMHSA-HRSA Center for Integrated Health Solutions, *Screening Tools*
http://www.integration.samhsa.gov/clinical-practice/screening-tools

ACHIEVING QUALITY IMPROVEMENTS

Medical homes will be carefully monitoring their quality data to identify opportunities for continuous improvement. While many community health centers have had experience and success with quality improvement activities, such quality improvement processes must become ongoing and continuous.

Medical Home Safety Net Initiative, *Resources on Quality Improvement Strategy*
http://www.safetynetmedicalhome.org/change-concepts/quality-improvement-strategy

Wagner EH, Coleman K, Reid RJ, Phillips K, Sugarman JR. *Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes*, The Commonwealth Fund (2012)
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patientcentered_med_home_v2.pdf

Institute for Healthcare Improvement, *Plan-Do-Study-Act*
http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/

American Academy of Family Physicians, *Family Practice Management Toolbox: Practice Improvement*
http://www.aafp.org/online/en/home/publications/journals/fpm/fpmtoolbox.html#Parsys61582

Landon BE, Hicks LS, O'Malley AJ, Lieu TA, Keegan T, McNeil BJ, Guadagnoli E. Improving the management of chronic disease at community health centers. *New Eng J Med*. (2007);356(9):921-934

Chin MH, Drum ML, Guillen M, Rimington A, Levie JR, Kirchhoff AC, Quinn MT, Schaefer CT. Improving and sustaining diabetes care in community health centers with health disparities collaboratives. *Med Care Res Rev.* (2007);45(12):1135-1143

IMPROVING PATIENT EXPERIENCE SCORES

Implementing “patient-centered” medical homes will require community health centers to pay more attention of patient experiences of care. As one element of the “triple aim”, improving patient experiences of care will require increased, ongoing collection of patient feedback and then the development and implementation of workflow changes and staff training to improve patient experiences.

National Committee for Quality Assurance, *Distinction in Patient Experience Reporting*
http://www.ncqa.org/PublicationsProducts/OtherProducts/PatientExperienceReporting.aspx

Medical Home Safety Net Initiative, *Resources on Patient-Centered Interactions*
http://www.safetynetmedicalhome.org/change-concepts/patient-centered-interactions

Brousseau R. *Toward a Better Patient Experience: Reengineering California’s Safety Net Clinics*, California HealthCare Foundation (2010)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/T/PDF%20TowardsABetterPatientExperience.pdf

American Academy of Family Physicians TransforMED, *Patient Experience Assessment Tool*
http://www.transformed.com/assessment-patient.cfm

American Academy of Family Physicians, *Family Practice Management Toolbox: Patient Surveys/Questionnaires*
http://www.aafp.org/online/en/home/publications/journals/fpm/fpmtoolbox.html#Parsys20275

American Academy of Family Physicians, *Family Practice Management Toolbox: Practice Improvement*
http://www.aafp.org/online/en/home/publications/journals/fpm/fpmtoolbox.html#Parsys61582

American Medical Association, *Improving Communication, Improving Care* (2006)
http://www.ama-assn.org/ama1/pub/upload/mm/369/ef_imp_comm.pdf

IMPROVING PATIENT EXPERIENCE SCORES (cont.)

Browne K, Roseman D, Shaller D, Edgman-Levitan S. Measuring patient experience as a strategy for improving primary care. *Health Aff.* (2010); 29(5):15-19

Institute for Family- and Patient-Centered Care, *Partnering with Patients and Families To Design a Patient- and Family-Centered Health Care System: Recommendations and Promising Practices* (2008)
http://www.ipfcc.org/pdf/PartneringwithPatientsandFamilies.pdf

Institute for Family- and Patient-Centered Care, *Advancing the Practice of Patient- and Family-Centered Care: How to Get Started...* (2008)
http://www.ipfcc.org/pdf/getting_started.pdf

Robert Wood Johnson Foundation Aligning Forces for Quality, *Engaging Consumers to Improve Ambulatory Care* (2012)
http://forces4quality.org/lessons-learned-engaging-consumers-improve-ambulatory-care-0

REPORTING TO PUBLIC HEALTH DEPARTMENTS

As part of improving population and community level health, medical homes will be expected to report health surveillance data to their local public health departments. Using electronic health records to report the data electronically will make such reporting routine.

National Learning Consortium, *Submitting Immunization Data to Public Health: HIE Scenario, Workflow and Specifications* (2012)
http://www.healthit.gov/providers-professionals/achieve-meaningful-use/menu-measures/immunization-registries#lftf

Centers for Disease Control and Prevention, *Immunization Information Systems* (2012)
http://www.cdc.gov/phin/library/PHIN_Fact_Sheets/FS_MU_IIS_2012_5_21.pdf

Centers for Disease Control and Prevention, *Advancing E-cancer Reporting and Registry Operations*
http://www.cdc.gov/cancer/npcr/informatics/aerro/index.htm

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