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Pursuing National Quality Recognition

There is a growing consensus that the US primary care system must be redesigned in fundamental ways to improve health and the patient experience while lowering costs (Knox et al., 2011). The current system's skyrocketing costs are unsustainable and present a serious threat to our national fiscal integrity, as well as to individual's and small businesses' abilities to obtain affordable, quality health care. The current fee-for-service payment model provides financial incentives to deliver more—and more costly—services and undermines health care providers' efforts to change practice patterns (Engelberg Center for Health Care Reform at the Brookings Institution and the Dartmouth Institute, 2010; Steinbrook, 2009).

According to the Agency for Healthcare Research and Quality (AHRQ), the patient-centered medical home (PCMH) model holds promise as a way to improve America's health care by transforming how primary care is organized and delivered (AHRQ, 2012). In the medical home approach to care, patients have a direct relationship with a provider who coordinates a team of individuals that takes collective responsibility for the ongoing care of patients, including effective coordination with other providers across a complex health care system. A PCMH health care setting aims to ensure quality care that is accessible, timely, comprehensive, and evidence-based (Patient-Centered Primary Care Collaborative, 2007).

Health care organizations that meet PCMH criteria are able to seek formal recognition or accreditation of their medical home program. HRSA's (Health Resources and Services Administration) Bureau of Primary Health Care (BPHC) supports HCH grantees in achieving national quality recognition through its Accreditation and Patient-Centered Medical/Health Home Initiatives. The Accreditation Initiative offers accreditation surveys through contracts with the Accreditation Association for Ambulatory Health Care (AAAHC) and The Joint Commission; the Patient-Centered Medical/Health Home Initiative offers surveys through a contract with the National Committee for Quality Assurance (NCQA). Achieving quality recognition from an independent review body shows patients and the community that the organization is committed to providing high-quality health care services (US Department of Health and Human Services [HHS], n.d.).

"I commend the HCH projects that have already achieved PCMH recognition," says the BPHC's Chief Medical Officer Seiji Hayashi,

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MD, MPH. "The HCH model is patient-centered and innovative. HCH projects deliver more enabling services and care coordination than do traditional primary care providers, so I encourage HCHs to apply for PCMH recognition to show that we can deliver quality care to all, regardless of their housing status or insurance coverage. Medical homes are rapidly becoming an expectation in the US health care system, and it is important that HCH centers not be left behind."

THE MEDICAL HOME MODEL
The medical home concept is not new. It was introduced by the American Academy of Pediatrics in 1967 as a model of care for children with specialized health care needs, and subsequently evolved into an integrated primary care model. The objective of the PCMH model is to assure that the patient gets the indicated care when and where they need and want it in a culturally and linguistically appropriate manner (National Committee for Quality Assurance, 2011a). The PCMH is central to HRSA's strategic goals, and HRSA has been funding projects on the medical home concept since the 1980s (AHRQ, 2011).

By definition, these characteristics are core to the medical home (AHRQ, 2012):

Comprehensive, team-based care. The PCMH is responsible for meeting the majority of the patient's physical and mental health needs, including acute, chronic, preventive, and end-of-life care. It takes a cohesive team of providers to provide comprehensive care, and this team may include physicians, nurses, social workers, medical assistants, care coordinators, educators, advanced practice nurses, physician assistants, and behavioral health providers. Small practices may build virtual teams by linking to services and other providers in their communities.

Person-centered orientation. The PCMH provides relationship-based primary care that meets the patient's unique needs, preferences, values, and goals. Engaging patients in their care is a key element of the medical home model, and the patient is a core member of the care team and an informed partner in establishing her or his care plan.

Coordinated care. The PCMH coordinates care across the broader health care system, including specialty care, hospitals, and community services and resources. Coordinated services result in better service delivery to all patients, including those with the most complex health needs.

Accessible services. The PCMH delivers accessible services in a variety of ways. Shorter waiting times, expanded hours, telephone or electronic access to a care team member, and alternative methods of communication such as email are ways of enhancing access to services.

Quality & safety. The PCMH demonstrates its system-level commitment to quality care and quality improvement through activities such as:

- Using evidence-based medicine and clinical decision-support tools
- Measuring and improving performance
- Improving patient safety, e.g., medication reconciliation
- Gathering and responding to patient experience data
- Practicing population health management
- Sharing quality and safety data and improvement activities publicly

THE ROLE OF HEALTH INFORMATION TECHNOLOGY

Using information technology (IT) in health care can improve the quality of care, even as it makes health care more cost-effective, and health IT plays a central role in successfully operationalizing and implementing the medical home's key functions (AHRQ, 2012). Primary care practices use health IT to support and coordinate quality patient care that is timely and appropriate. Health IT helps to consistently capture accurate information and easily report on identified process and outcome measures, eliminating the need for time-consuming chart reviews. These reports can be used to review population trends among groups and to track patient progress (Healthcare Information and Management Systems Society [HIMSS], 2010).

In the medical home setting, information technology supports performance measurement, patient education, and enhanced communication (Patient-Centered Primary Care Collaborative, 2007). Using electronic medical records (EMRs) gives an HCH project the ability to close communication gaps and identify patients who need specific follow-up. Health IT has the potential to improve communication among staff, and between staff and outside providers such as labs, imaging centers, and subspecialists. By allowing the health center to compare results among providers and practices, health IT can expand performance improvement in all clinical activities (HIMSS, 2010).

A recent survey of HCH grantees found that about two-thirds (65 percent) of those responding use EMRs at some or all of their sites. Of those currently without EMRs, 82 percent of survey respondents reported planning to implement the use of EMRs within the next six to 12 months (National Health Care for the Homeless Council [NHCHC], 2011).

Although HCH projects that are in the early stages of transformation to the PCMH model do not necessarily need EMRs to be recognized as NCQA Level 1 medical homes, these types of health IT are recommended to achieve Level 2 or 3 recognition (HIMSS, 2010):

- Electronic record keeping
- Electronic disease registries
- Internet communications with patients
- Electronic prescribing

THE PCMH ADVANTAGE

In 2008, a federal workgroup of agencies from across the Department of Health & Human Services collaborated to develop a conceptual model of the medical home. This workgroup concluded that the medical home is a conduit to:

- lowering health care costs
- increasing quality
- reducing health disparities
- achieving better outcomes
- lowering utilization rates
- improving compliance with recommended care
- coordinating a spectrum of medical & social services required by the individual across the lifespan

Source: Mann, 2010

"In my brief career as medical director, I've already had experience with eight different EMRs, and I've learned there is no one perfect system. Each has its strengths and weaknesses. Review the clinical practice tools that are included in your system and make sure that your providers use them consistently. Look for ways to make it easy for providers to use the system. For example, our medical assistants open the chronic disease template for the conditions we track—asthma, diabetes, hypertension—when they know that the patient is coming in for that condition," says **Phillip M. Dove, MD**, chief medical officer of Yakima Neighborhood Health Services in Yakima, Washington.

THE ROAD AHEAD . . .

A survey of HCH grantees conducted in 2011 found that about 8 percent of survey participants had received PCMH recognition from NCQA; another 1 percent had received primary care medical home accreditation from The Joint Commission (NHCHC, 2011). The National Health Care for the Homeless Council (NHCHC) is working to get all HCH grantees recognized by 2014, according to Deputy Director **Melissa DaSilva, MS, RN**.

"That's when the largest changes of health reform go into effect," DaSilva says, "and it is critical that HCH projects are able to demonstrate how they are integral and relevant to the larger health care system of hospitals, and local, state, and federal programs. Even with health care reform, there will be a need for the safety net. HCH projects need to prepare to compete in the new environment.

"HCH projects may dread redesigning clinical and administrative systems and fear that serving homeless people may present insurmountable barriers to achieving quality recognition," DaSilva says, "but it is important that leadership embrace this process and realize that it is doable. The Safety Net Medical Home Initiative website [www.qhmedicalhome.org] has resources that focus on the vital role that leaders play in driving and sustaining PCMH transformation. The *Engaged Leadership Implementation Guide* presents concrete strategies that are particularly helpful to HCH leaders."

"We need to anticipate what the health care system may look like in 2015 – 2016," adds **Barbara DiPietro, PhD**, NHCHC's policy director. "Although there isn't a mandate to receive PCMH certification now, we can anticipate that in the future a transformed system will reward and pay for performance and achieving good outcomes. Currently,

states are making decisions about how they will proceed with implementing health reform, and service providers and organizations that care for low-income and homeless clients need to be active at the state level. We must be tenacious and go armed with data to assure that the implementation takes into consideration the needs of those experiencing homelessness."

PCMH/HCH INTERSECTION

The health care for the homeless model of care provides a solid foundation for HCH projects that wish to pursue PCMH recognition (Goyer, 2011). Although HCH grantees vary considerably, a number of common elements put them in good stead when seeking quality recognition. Outreach, case management, walk-in and same day appointments, collaboration with community partners, transdisciplinary teams, integrated primary care and behavioral health, trauma-informed care, motivational interviewing, and consumer participation are hallmarks of homeless health care. HCH clinicians meet people where they are, illustrating that the patient is at the heart of HCH care.

"HCH projects already embody the health home approach. We know collaboration, teamwork, engagement, and integrated care," says DiPietro, "we've been doing it for 25 years. Now it's time for other primary care providers to catch up."

In spite of these strengths and their close alignment with the basics of the PCMH approach, there are challenges for HCHs seeking PCMH recognition. For many HCHs, using technology and documentation to convert informal processes into formal systems will be the biggest obstacle to becoming a true medical home.

TAKE THE CHALLENGE: YOU CAN DO IT!

"I really believe in the process of seeking PCMH recognition. It's very positive," says **Nancy L. Rothman, EdD, RN**, consultant to Philadelphia's Mary Howard Health Center. "Along with leading to patient quality care, it leads to a quality work environment for providers and the staff as a whole." Operated by Public Health Management Corporation, Mary Howard is a nurse-managed comprehensive primary health care center specifically for homeless people. The center received NCQA Level 1 recognition in 2009 and is working towards Level 3 recognition status in 2012.

"Pursuing recognition helps clinicians see where they are and where they need to improve. At Mary Howard, for example, we learned that referral and test tracking and follow-up were areas needing improvement," Rothman says. "Although we had a system in place at one location, we needed to implement it across our three locations. This change required practice reengineering, and now we have an improved system for tracking our referrals and tests.

"The day before the patient's appointment with a specialist, our referral manager calls the patient to remind them of the appointment. On the day of the appointment, we call the specialist to confirm that the patient showed up. If we don't receive the specialist's report, we'll call to request it. The patient's chart is flagged for the provider, who will review the report."

THE FIVE *As* OF SELF-MANAGEMENT SUPPORT & CLINICAL COUNSELING

Assess: Determine beliefs, behavior & knowledge, conviction & confidence

Advise: Provide specific information about health risks & benefits of change

Agree: Collaboratively set goals based on patient priorities, conviction & confidence in his or her ability to change or self-manage

Assist: Identify personal barriers, strategies, problem-solving techniques & social supports

Arrange: Specify a plan for follow-up assessment & support such as visits, phone calls, emails or other contact methods between the patient & medical home

Source: Adapted from Whitlock et al., 2002

Many of Mary Howard's patients have cell phones, and some shelters will help by leaving a message to remind a patient of a medical appointment. Many HCH projects nationwide use Community Voice Mail (www.cvm.org) for communicating with clients.

"We're able to see how long it takes patients to get specialist appointments—and if it's taking too long—we will talk to that provider," Rothman continues. "We also look at the type of insurance the patient has to see if this is a factor in the time it takes to get an appointment. If we see a pattern of delay because the patient has Medicare or Medicaid, we contact our representative from that payer type to let them know of the disparity.

"A major shift in our practice has been in our new emphasis on self-management. The old model of telling people what to do simply doesn't work. In effective self-management, the patient plays a central role in determining their care by setting their own goals, and the clinician provides support to help the patient meet those goals. We hired RN care managers to work with patients to establish self-management goals and develop the patient's personal action plan. Team-based care leads to great outcomes, and the enhanced documentation and reporting associated with the PCMH enables you to see that you *are* making a difference," Rothman says.

Patient receiving care at the Mary Howard Health Center

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GOOD STARTING POINTS

HRSA's Program Assistance Letter (PAL) 2011-01. HRSA promotes continuous quality improvement in health centers including HCH grantees. This PAL describes HRSA's Patient-Centered Medical/Health Home (PCMHH) Initiative, which encourages grantees to seek PCMH recognition and demonstrate their leadership as providers of high-quality care. The PAL describes the processes and requirements for applying for PCMH recognition, and lists technical assistance, training, and educational resources. The fee for gaining NCQA PCMH recognition is waived for HCH projects participating in the PCMHH Initiative (a link to PAL 2011-01 is in the resource toolkit, page 6).

Recognition or accreditation? Before moving forward, agencies will need to decide whether to pursue accreditation from AAAHC or The Joint Commission or recognition from NCQA. Two documents can help with this analysis. HRSA has a chart comparing accreditation from AAAHC and The Joint Commission to recognition from NCQA (online at http://bphc.hrsa.gov/policiesregulations/policies/qualrecogn.pdf), and the *PCMH Resource Catalogue* complied by the Council will also help compare options (www.nhchc.org/wp-content/uploads/2012/01/PCMH-Resource-Catalogue.pdf).

Do your homework. The resource toolkit on pages 5 – 7 provides links to a wealth of practical and essential information. The case studies of homeless grantees Mary Howard Health Center and Yakima Neighborhood Health Services—listed under webcasts—are a great place to start. These webcasts provide homeless-specific examples and walk through the required elements for recognition. A PowerPoint presentation of interest is Hudson Headwaters' Journey to PCMH Recognition, which includes two slides that outline initial steps to getting started.

"The Safety Network Medical Home Initiative website is the ultimate guide to practice transformation," recommends **Stephanie Luther, MD**, senior medical officer at Heartland Health Outreach in Chicago. "And the Community Health Care Association of New York and the Primary Care Development Corporation have good materials, too," says **Peter Lopatin**, Heartland's director of quality management.

NCQA standards. "Download the free PCMH standards, guidelines, and application from the NCQA website," advises Rothman. "Next, purchase NCQA's Interactive Survey System Tool and a license for each site to be recognized. Compare the requirements for recognition with what you are doing now. Be honest with yourself. Take advantage of the free online training, and I highly recommend the regional classroom training where you'll learn how to demonstrate that you are meeting the criteria. It's expensive, but invaluable."

Form a workgroup. "HCH projects can start by convening a small strategic planning workgroup that includes the medical director," advises **Claire F. Goyer, MEd**, technical assistance coordinator for the NHCHC. "Take the NCQA standards and walk through them, doing an internal assessment of where your center is in relationship to the standards, and where you need to improve. You could also assign this task to an existing QI [quality improvement] team, if your center has one.

"The standards provide clear and specific criteria and serve as a roadmap to guide your next steps," says Goyer. "It's not as daunting as most people think, and you'll see that you are closer to meeting the standards than you would have guessed. Most HCH projects can achieve Level 1 recognition with few modifications to existing systems."

Peer-to-peer learning. "Speak to other HCH projects similar to yours that have earned PCMH Level 1 recognition," Goyer recommends. "Discuss their experiences in preparing to meet NCQA standards and how they transformed their practice into a true medical home." There are a couple of ways to learn which health centers or HCH projects have already received PCMH recognition. Contact your federal project officer and he or she can facilitate the process of connecting you with an already recognized grantee; another option is to contact **Juli Hishida**, the Council's technical assistance coordinator, at jhishida@nhchc.org.

Contact your state primary care association. Most state PCAs have resources to help safety net providers achieve quality recognition, and some have staff with specialized expertise in health care transformation.

Collaborate with a Health Center Controlled Network. An HCCN is a group of safety net providers—a minimum of three—that collaborate to improve access to care, enhance quality of care, and achieve cost efficiency. HCCNs exist to ensure health care access to medically underserved populations by enhancing health center operations, including health IT (Health Resources and Services Administration, n.d.). "Being part of an HCCN allowed us to develop EMR templates capturing those HCH services that define and enrich what PCMH aims for: coordinated, multidisciplinary services that are patient-focused," says **Rhonda Hauff**, chief operating officer/deputy chief executive officer for the Yakima Neighborhood Health Services in Yakima, Washington.

"The HCCN may provide an opportunity to outsource data management and report writing. It's a great example of what you can do when you reach outside your own agency and partner with others," says Health Disparities Consultant **Anna M. Gard, FNP-BC**, who works with the Association of Clinicians for the Underserved as well as the Council on issues related to PCMH. Links to PCAs and HCCNs are in the resource toolkit on page 7.

PRACTICE PEARLS: KEYS TO ACHIEVING QUALITY RECOGNITION

"The key to success is having a clinician who is a quality champion and an IT specialist who understands the importance of documenting outcomes. These two individuals must collaborate to create a reporting system that can provide the information needed—not only to meet the accreditation standards, but to provide data that can be used to improve your practice."

—Nancy L. Rothman, EdD, RN
Mary Howard Health Center, PHMC, Philadelphia

BENEFITS OF ACHIEVING QUALITY RECOGNITION

- Validation of your work; improved staff satisfaction & morale
- Streamlined processes, greater efficiency & improved customer service
- Improved access to care; enhanced quality of care
- Potential for enhanced revenue
- An objective assessment of your practice

Source: HIMSS, 2010

"Work with your consumer advisory board. Ask the CAB for recommendations about aspects of the standards you feel uncertain about. For example, the standard related to enhanced access and continuity describes an electronic clinical summary of the primary care visit that might include diagnoses, medications, recommended treatment and follow-up. Although your EMR may be capable of generating one of these for every patient, that doesn't mean that you must give it to the patient if it puts them at risk because of their relative lack of privacy when living on the street or in shelter. Hold a focus group discussion with CAB members to learn what information they need and how they want it: on paper, on a USB flash drive that could be worn on a lanyard, or as a web-based document that can be accessed through a secure, interactive system."

—Anna M. Gard,
FNP-BC, Health Disparities Consultant
Association of Clinicians for the Underserved

"Regard the transformation to a medical home as an opportunity to improve staff morale, achieve good patient outcomes, and meet your strategic objectives."

—Claire F. Goyer, MEd,
TA Coordinator
National Health Care for
the Homeless Council

NCQA's PCMH 2011 STANDARDS
1. Enhance access & continuity
2. Identify & manage patient populations
3. Plan & manage care
4. Provide self-care support & community resources
5. Track & coordinate care
6. Measure & improve performance

Source: National Committee for Quality Assurance, 2011b

"Keep it simple. Don't make it harder than it has to be."

—Rhonda Hauff, COO/Deputy CEO
Yakima Neighborhood Health Services, Yakima, Washington

TOOLKIT OF PRACTICAL RESOURCES TO HELP ACHIEVE PCMH RECOGNITION

PCMH Standards, Guidelines & Application Materials

National Committee for Quality Assurance (NCQA) | Patient-Centered Medical Home	www.ncqa.org
Accreditation Association for Ambulatory Health Care (AAAHC) | Medical Home Accreditation	www.aaach.org
The Joint Commission | Primary Care Medical Home Accreditation	www.jointcommission.org/accreditation/pchi.aspx

How-To Guides

Building Your Medical Home Toolkit	www.pediatricmedhome.org
Developing & Running a Primary Care Practice Facilitation Program: A How-to Guide | AHRQ | 2011	http://pcmh.ahrq.gov/portal/ server.pt/community/pcmh__home/1483
Obtaining PCMH Recognition: A How-To Manual A Guide for Obtaining PPC-PCMH Recognition for Safety-Net Providers | 2009	www.pcdc.org/assets/pdf/pcdc-pcmh-manual-2009.pdf
Steps to NCQA Recognition for PCMH | June 2011	www.nhchc.org/2011/06/steps-ncqa-recognition-patient-centered-medical-home
Nine Steps to NCQA PCMH Recognition	www.nhchc.org/wp-content/uploads/2012/01/ 9-Key-steps-to-NCQA-PCMH-Recognition.pdf

Webcasts & PowerPoint Presentations

Health IT & Quality Webinars: Upcoming & archived webcasts for HRSA grantees planning to use health IT to improve patient care quality	www.hrsa.gov/healthit/toolbox/webinars/index.html
Building Blocks for Staffing Your PCMH | Three-part webinar series | February – April 2012	www.nachc.com/client//Promotion%201_Clinical% 20Workforce%20Webinar%20Series_1-26-12.pdf
Designing a Successful Quality Improvement Program: Team Building & Writing a QI Plan | HRSA/BPHC | 2011	www.hrsa.gov/publichealth/guidelines/ designqualityimprove.ppt
Hudson Headwaters' Journey to PCMH Recognition	www.nhchc.org/wp-content/uploads/ 2012/02/HHPCMHJourney.pdf

TOOLKIT OF PRACTICAL RESOURCES TO HELP ACHIEVE PCMH RECOGNITION, *continued*

Medical Home & Patient-Centered Care Webinars — www.nashp.org/node/28

PCMH & Homeless Health Care: An Introduction — www.nhchc.org/2012/01/patient-centered-medical-home/

PCMH: A Case Study on Achieving Level 3 | August 2011 — www.nhchc.org/2011/08/patient-centered-medical-home-case-study-achieving-level-3

PCMH Case Study Featuring Yakima Neighborhood Health Services | November 2011 — www.nhchc.org/2011/11/patient-centered-medical-home-case-study-featuring-yakima-neighborhood-health-services/

PCMH Case Study Featuring Mary Howard Health Center | December 2011 — www.nhchc.org/2011/10/patient-centered-medical-home-case-study-featuring-mary-howard-health-center

Chronic Care Model Presentation | Ed Wagner, MD, MPH | 2004 — www.improvingchroniccare.org/index.php?p=The_Model_Talk&s=27

Multimedia presentations from the American College of Physicians, including one for patients (in English & in Spanish — www.acponline.org/running_practice/pcmh/resources_tools/multimedia.htm

Tips for Implementing Your Health Center Quality Improvement Program | HRSA/BPHC | 2011 — www.hrsa.gov/publichealth/guidelines/qualityimprove.pptx

Background Reading & Policy Considerations

HRSA Patient-Centered Medical/Health Home Initiative | PAL 2011-01 — http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html

Affordable Care Act: Read the Law — www.healthcare.gov/law/full/index.html

Building Medical Homes: Lessons from Eight States with Emerging Programs | 2011 | National Academy for State Health Policy & The Commonwealth Fund — www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2011/Dec/1569_Kaye_building_medical_homes_v2.pdf

Health Reform & Homelessness | 2011 Policy Statement — www.nhchc.org/wp-content/uploads/2011/10/HealthReformandHomelessness2011.pdf

The State of Quality Improvement Science in Health: What Do We Know About How to Provide Better Care? | Robert Wood Johnson Foundation — www.rwjf.org/qualityequality/product.jsp?id=73634&cid=XEM_205605

Joint Principles of a PCMH Released by Organizations Representing More Than 300,000 Physicians | American College of Physicians | 2007 — www.acponline.org/pressroom/pcmh.htm

Fact Sheet: Medicare-Medicaid Advanced Primary Care Demonstration Initiative — http://healthreform.gov/newsroom/factsheet/medicalhomes.html

Health Information Technology (HIT) & Electronic Health Records (EHRs)

Fact Sheet & Case Examples: HIMSS & NCQA — www.himss.org/content/files/LeveragingHealthITAchieveAmbulatoryQuality6-8-10.pdf

Health IT Regional Extension Centers — www.regionalextensioncenters.com

Health IT Tools & Resources | AHRQ — http://healthit.ahrq.gov/portal/server.pt/community/health_it_tools_and_resources/919

HRSA Health IT Adoption Toolbox: Assistance & Resources for the Various Stages in Implementing Health IT — www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/index.html

HIT: Addressing Health Disparity by Improving Quality, Increasing Access & Developing Workforce — www.clinicians.org/images/upload/Health_IT.pdf

NACHC HIT: Your One Stop Resource — www.nachc.com/Health%20Information%20Technologies%20%28HIT%29.cfm

TOOLKIT OF PRACTICAL RESOURCES TO HELP ACHIEVE PCMH RECOGNITION, *continued*

The Office of the National Coordinator for Health Information Technology | HHS — http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204

Regional Health Information Organizations (RHIOs) — www.himss.org/statedashboard

Workflow Assessment for Health IT Toolkit | AHRQ — http://healthit.ahrq.gov/portal/server.pt/community/health_it_tools_and_resources/919/workflow_assessment_for_health_it_toolkit/27865

Technical Assistance & Training

Free Recognition Training Programs from NCQA — www.ncqa.org/tabid/109/Default.aspx

NHCHC TA Request Form — www.nhchc.org/training-technical-assistance/technical-assistance-request-form

Pre-conference Institute on Primary Care & Medical Home | National Health Care for the Homeless Conference | May 2012 | Kansas City, MO — www.nhchc.org/national-conference-2012/agenda

Searching for HCCNs — http://findanetwork.hrsa.gov/Help/About_Search_Settings.htm

State Primary Care Associations — http://bphc.hrsa.gov/technicalassistance/partnerlinks/associations.html

Primary Care Development Corp | Medical Home Transformation (Note: costs for onsite services based on scope of work) — www.pcdc.org/performance-improvement/pi-solutions/medical-home-transformation.html
Dane Ligoure | 212/437-3926 | dligoure@pcdc.org

Websites

Safety Network Medical Home Initiative — www.qhmedicalhome.org/safety-net

National Academy for State Health Policy — www.nashp.org/med-home-map

National Center for Medical Home Implementation — www.medicalhomeinfo.org

PCMH Resource Center | AHRQ — http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483

Free Newsletter

H2RMinutes: News for professionals interested in patient-centered care — www.h2rminutes.com/main.html

More Related Resources . . .

Bring Community Voice Mail to Your Area — www.cvm.org/starting.cfm

Self-management support: Helping clients set goals to improve their health | Morrison | 2007 — www.nhchc.org/SelfManagementSupport052907.pdf

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Health Resources and Services Administration. (n.d.). *HCCN fact sheet: Health Center Controlled Networks*. Rockville, MD: US Department of Health and Human Services. Retrieved from http://www.hrsa.gov/healthit/toolbox/HealthITadoptiontoolbox/OpportunitiesCollaboration/abouthccns.html

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